(1)

91-782

NO.

IN THE SUPREME COURT OF THE
UNITED STATES

OCTOBER TERM, 1991

KAREN SNIDER, Acting Secretary
of the Department of Public Welfare,
Commonwealth of Pennsylvania, et al.,
Petitioners

v.

TEMPLE UNIVERSITY--OF THE COMMONWEALTH
SYSTEM OF HIGHER EDUCATION, et al.,
Respondents

On Petition for Certiorari To The
United States Court of Appeals
for the Third Circuit

PETITION FOR CERTIORARI

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QUESTIONS PRESENTED

I. Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. §1983 to enforce the Medicaid Act against a State?

II. Whether a federal court can attribute to Congress an unstated intent to impose on a state increased funding obligations under the Medicaid Act?

LIST OF PARTIES

The petitioners are Karen Snider, the Acting Secretary for the Pennsylvania Department of Public Welfare (DPW); David S. Feinberg, the Acting Deputy Secretary for the Office of Medical Assistance Programs, DPW; David D. Ulsh, the Director of the Division of Inpatient Programs, Bureau of Hospital and Outpatient Programs, Office of Medical Assistance Programs, DPW; G. June Hoch, Chief of Specialty Hospital Programs, Division of Inpatient Programs, Bureau of Hospital and Outpatient Programs, Office of Medical Assistance Programs, DPW; Michael H. Hershock, the Secretary for Budget, Office of the Budget, Governor's Office, Commonwealth of Pennsylvania; Carolyn Franklin, Western Regional Representative of Public Welfare, DPW; and Patricia Hughes, Southeastern

Regional Representative of Public Welfare, DPW.

The respondents are Temple University, Albert Einstein Medical Center, Allegheny General Hospital, Children's Hospital of Pittsburgh, Episcopal Hospital, Giuffre Medical Center, Magee-Women's Hospital, Mercy Catholic Medical Center- Misericordia Division, Mercy Hospital of Pittsburgh, Montefiore Hospital Association of Western Pennsylvania, Inc., Presbyterian University Hospital of Pittsburgh, St. Christopher's Hospital for Children, St. Joseph's Hospital, St. Mary Hospital, Western Pennsylvania Hospital, Germantown Hospital and Medical Center, Hahnemann University Hospital, Presbyterian Medical Center of Philadelphia, the Trustees of the University of Pennsylvania, Allegheny Valley Hospital, The Allentown Hospital,

Allentown Osteopathic Medical Center, J.C. Blair Memorial Hospital, Braddock General Hospital, Bradford Hospital, Brandywine Hospital, Butler Memorial Hospital, Carbondale General Hospital, Central Medical Center and Hospital, Chambersburg Hospital, Chester County Hospital, Chestnut Hill Hospital, The Children's Hospital of Philadelphia, Charles Cole Memorial Hospital, Clarion Osteopathic Community Hospital, Clearfield Hospital, Community General Osteopathic Hospital, Community Medical Center, Conemaugh Valley Memorial Hospital, Divine Providence Hospital, Divine Providence Hospital of Pittsburgh, Doylestown Hospital, Dubois Regional Medical Center, Ephrata Community Hospital, Eye & Ear Hospital of Pittsburgh, Forbes Metropolitan Health Center, Forbes Regional Health Center,

Franklin Regional Medical Center, Frick Community Health Center, Geisinger Medical Center, Geisinger Wyoming Valley Medical, The Germantown Hospital and Medical Center, Gettysburg Hospital, Gnaden Huetten Memorial Hospital, Good Samaritan Hospital, Greene County Memorial Hospital, Hamot Medical Center, Hanover General Hospital, Harrisburg Hospital, Highlands Hospital and Health Center, Indiana Hospital, Jameson Memorial Hospital, Jeannette District Memorial Hospital, Jefferson Hospital, Andrew Kaul Memorial Hospital, Kensington Hospital, Lancaster General Hospital, Lankenau Hospital, Lee Hospital, Lehigh Valley Hospital Center, McKeesport Hospital, Meadville Medical Center, The Meadville Medical Center, Beaver, Pa., Inc., Medical College of Pennsylvania, Memorial Hospital, Memorial Hospital of

Bedford, Mercy Catholic Medical Center, Fitzgerald Mercy Division, Mercy Hospital, Altoona, Methodist Hospital, Millcreek Community Hospital, Monongahela Valley Hospital, Muhlenburg Hospital Center, Northeastern Hospital of Philadelphia, North Penn Hospital, Osteopathic Medical Center of Philadelphia, Pennsylvania Hospital, Phoenixville Hospital, Pottstown Memorial Medical Center, Pottsville Hospital and Warne Clinic, Punxsutawney Area Hospital, The Penn State Hospital/Milton S. Hershey Medical Center, Quakertown Community Hospital, Reading Hospital and Medical Center, Roxborough Memorial Hospital, St. Agnes Medical Center, St. Francis Medical Center, St. Joseph's Hospital, Carbondale, St. Joseph Hospital, Lancaster, Sacred Heart Hospital, Sewickley Valley Hospital,

Shadyside Hospital, Sharon General Hospital, Southern Chester County Medical Center, Suburban General Hospital, Sunbury Community Hospital, Taylor Hospital, Tyler Memorial Hospital, Tyrone Hospital, Westmoreland Hospital Association, Wilkes-Barre General Hospital, The Williamsport Hospital & Medical Center, York Hospital and Greenville Regional Hospital, Altoona Hospital, Bloomsburg Hospital, Brownsville Hospital, Bryn Mawr Hospital, Canonsburg Hospital, Carlisle Hospital, Citizens General, Community General Hospital, Reading, Community Hospital of Lancaster, Crozer-Chester Hospital, Delaware County Memorial Hospital, Easton Hospital, Ellwood Hospital, Grand View Hospital, Jeanes Hospital, Jersey Shore Hospital, J.F. Kennedy Hospital, Lower Bucks Hospital, Metro Health Hospital,

Metropolitan Hospital, Central, Metropolitan Hospital, Parkview, Metropolitan Hospital, Springfield, Montgomery Hospital, Paoli Hospital, Pocono Hospital, Sacred Heart Hospital-Chester, Saint John's Hospital, Hazelton-Saint Joseph's Medical Center, Saint Joseph Hospital, Reading, Saint Luke's Hospital, Saint Margaret Memorial Hospital, Saint Vincent's Hospital, Suburban Hospital, Titusville Hospital, Uniontown Hospital, Washington Hospital, and The Wayne County Memorial Hospital.

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The Opinion of the United States Court of Appeals for the Third Circuit is reported at 941 F.2d 201 and is reprinted in the appendix at 1a. The opinions of the United States District Court for the Eastern District of Pennsylvania are reported at 729 F.Supp. 1093 and 732 F.Supp. 1327, and are reprinted in the appendix at 53a and 93a, respectively.

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was filed on July 30, 1991, App. 1a, and this petition is being filed within 90 days thereafter. The Court has jurisdiction to review this judgment pursuant to 28 U.S.C. §1254(i).

STATUTORY PROVISIONS INVOLVED

1. 42 U.S.C. § 1983 provides in relevant part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State ... subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in any action at law, suit in equity, or other proper proceeding for redress.

2. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396a-19396u, known as the Medicaid Act, provides in relevant part, at 42 U.S.C. § 1396, as follows:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children whose income and resources are insufficient to meet the costs of necessary medical

> services...there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

3. 42 U.S.C. § 1396a(a) of the Medicaid Act also provides in relevant part:

> A State plan for medical assistance must--...
>
> (13) provide--
>
> (A) for payment ... of the hospital services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and

> economically operated facilities ... and to assure that individuals eligible for medical assistance have reasonable access ... to inpatient hospital services. ...

4. 42 U.S.C. § 1396r-4 of the Medicaid Act further provides in relevant part:

> [A] payment for a disproportionate share hospital must either --
> (1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);
> (2) provide for a minimum specified additional payment amount (or increased percentage payment) and ... for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate ... exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in

the State or the hospital's low income utilization rate ...; or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that --

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients.

STATEMENT OF THE CASE

1. This action challenges Pennsylvania's administration of the Medical Assistance or "Medicaid" program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, 1396a-1396u. The respondents, Medicaid providers and a representative organization, attack the adequacy of the payment rates Pennsylvania has established for their services. In particular, they claim that the disproportionate share payment made by the Pennsylvania Department of Public Welfare (DPW) is lower than the level of payment mandated by 42 U.S.C. § 1396r-4.

a. Medicaid is an exercise in "cooperative federalism," Harris v. McRae, 448 U.S. 297, 308 (1980), in which the state and federal governments work together to provide, "as far as

practicable under the conditions in each state," medical assistance to poor people. 42 U.S.C. § 1396. To receive the federal financial assistance made available by the act, a state must submit to the Secretary of Health and Human Services, and have approved by him, a "state plan," ibid, the contents of which are prescribed by 42 U.S.C. § 1396a(a).

Regarding hospital services, the act requires that the state plan "must ... provide ... for payment ... through the use of rates ... which the state finds, and makes assurance satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a) (13)(A). These payments must also take into account the situation of hospitals serving disproportionate numbers of poor patients. Ibid.

The act specifically defines these "disproportionate share" hospitals, 42 U.S.C. § 1396r-4(b), and requires the state plan to provide for an "appropriate increase," 42 U.S.C. § 1396r-4(a)(1)(B), in their payment rates. In setting this "appropriate increase," a state plan may adopt the figure used in the federal Medicare program, 42 U.S.C. § 1396r-4(c)(1), or may adopt its own methodology, 42 U.S.C. §§ 1396r-4(c)(2), 1396r-4(c)(3). If the state chooses to use its own methodology, the "appropriate increase" must be proportionate to the percentage by which a hospital's share of medicaid- eligible patients exceeds the norm, 42 U.S.C. § 1396r-4(c)(2), or must be "reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance," 42 U.S.C. § 1396r-4(c)(3)(B).

b. When it submitted State Plan Amendment 88-12 to the Health Care Financing Administration (HCFA), DPW chose not to use the Medicare formula for determining disproportionate share payments. Instead, as authorized by statute, DPW determined the disproportionate share payment as follows:

(1) The hospitals were ranked, from high to low, by the hospital's ratio of federally funded medical assistance days (Title XIX days) to total days;

(2) The rankings were divided into five payment brackets with ties resolved by moving a hospital into the next higher bracket; and

(3) For fiscal year (FY) 1988-89, qualifying hospitals, of which there were 48, received

the following add-ons to their group rate:

Payment Bracket	Percentage Add-On	No. of Hospitals
1	2.5%	11
2	2.0%	10
3	1.5%	11
4	1.0%	12
5	0.5%	4

HCFA, consistent with its statutory authority, approved DPW's disproportionate share payments, as prescribed in State Plan Amendment 88-12, on August 28, 1989.

2. This action was brought originally as several separate but related actions before the United States District Court for the Eastern District of Pennsylvania. The District Court had jurisdiction of these related actions pursuant to 28 U.S.C. §§ 1331, 1343.

Although recognizing that the "statute does not mandate any particular level of payments for disproportionate-share hospitals," App. 81a, the District Court initially held that DPW's rates failed "to adequately take into account the circumstances of hospitals which serve a disproportionate number of low-income patients with special needs." App. 88a. The District Court stated:

> By specifying either the Medicare system or an alternative system devised by the States, Congress seems to have contemplated that the State's plan would produce comparable results. The 2.5% override provided by the Pennsylvania Plan is only about 1/10 of the amount which would be payable [to Temple University] under the Medicare analysis (2.5% versus 20.93%).

> Recognizing that States are given a considerable amount of flexibility in this area, and that reimbursement rates are to be fixed by the State, not by this court, I am nevertheless constrained to hold that Pennsylvania's adjustment for plaintiff's disproportionate-share status misses the mark by so wide a margin as to be inconsistent with the intent of Congress.

App. 82a-83a. In later granting interim relief, the District Court stated that "Congress intended disproportionate share institutions to receive an adjustment in the same ball park as the Medicare calculation would produce." App. 99a. Based upon a comparison with the Medicare rate, the Court found "on an interim basis, the disproportionate share add-on [for Temple University] should not be less than 10%." App. 100a-101a.

The District Court also found that DPW's basic Medicaid payment rates, were "arbitrary, and inadequate to meet the costs which must be incurred by efficiently and economically operated hospitals." App. 91a. In switching to a prospective payment plan, DPW applied an adjustment factor to limit the payments to an estimated amount that would have been paid under the old system. Consequently, DPW, after regrouping the hospitals, reduced the group average rates by a "budget neutrality factor" of approximately 14%. The District Court held that DPW failed to make the requisite findings that the rates were "reasonable and adequate" and thereby violated federal law. 42 U.S.C. § 1396a(a)(13)(A). App. 83a-87a. In the form of interim relief, the Court ordered that DPW apply to Temple University a budget neutrality reduction of no greater

than 2.4%. App. 98a-99a, 103a. In subsequent orders, the District Court applied identical interim relief to all the other respondents. App. 105a-112a.

3. The Court of Appeals for the Third Circuit had jurisdiction to review the orders of the District Court pursuant to 28 U.S.C. § 1292(a).

The Court of Appeals, after consolidating the appeals, affirmed the orders of the District Court.[1] The

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1 Before the Third Circuit rendered its decision, the petitioners and respondents entered into a Stipulation of Settlement. Under that Stipulation, the parties agreed to place the litigation in civil suspense for three years and to engage in a series of pooling transactions designed to draw down additional federal matching funds for the payment of enhanced rates. The Court of Appeals acknowledged the "highly conditional nature of the settlement" and found that the appeals had not been mooted. App. 17a-18a.

The pooling transactions have now been imperiled by interim federal regulations promulgated by the Health Care Financing Administration at 56 Fed. Reg. 46,380 (September 12, 1991). As a result, the issues raised by this petition are even more clearly not moot.

Court of Appeals did not specifically address the issue of whether disproportionate share payments under Medicaid must be comparable to the disporportionate share payments under the Medicare Program. It merely stated that the District Court found the 2.5 % add-on for Temple to be inadequate and then, after discussing the other issues, affirmed the orders "in all respects." App. 14a-15a, 51a.

This appeal followed.

REASONS FOR GRANTING THE WRIT

I. THIS CASE PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW THAT SHOULD BE REEXAMINED BY THIS COURT AS TO WHETHER A MEDICAID PROVIDER HAS A PRIVATE FEDERAL CAUSE OF ACTION UNDER 42 U.S.C. § 1983 TO ENFORCE THE MEDICAID ACT AGAINST A STATE.

In Wilder v. Virginia Hospital Association, ___ U.S. ___ 110 S.Ct. 2510 (1990), the Court held, in a 5-4 decision, that the Medicaid Act is enforceable in federal court pursuant to 42 U.S.C. § 1983. For the reasons explained in the dissent in that case per Chief Justice Rehnquist, and for the reasons set forth below, Wilder should be overruled.

As this Court recently held, precedent which is determined to be wrong ought not be followed slavishly, particularly when, as here, the holding in question was endorsed by the narrowest possible majority. Payne v. Tennessee, ___ U.S. ___, 111 S. Ct. 2597

(1991). Although constitutional precedents are generally more susceptible to being overruled than statutory ones, id. at 2610, section 1983 litigation raises quasi-constitutional issues. As Justice Powell once explained:

> The issued raised under § 1983 concerns a 'basic problem of American federalism' that 'has significance approximating constitutional dimension.' Monroe v. Pape, 365 U.S. at 22, 81 S.Ct. at 503 ([Frankfurter, J.] dissenting opinion). Although Mr. Justice Frankfurter's view did not prevail in Monroe, we have heeded consistently his admonition that the ordinary concerns of stare decisis apply less forcefully in this than in other areas of law.

Maine v. Thiboutot, 448 U.S. 1, 33 (1980) (Powell, J. dissenting). Principles of federalism, overlooked by the majority in Wilder and confirmed by events since that decision, counsel in favor of reconsideration of the Wilder majority's conclusion that the Medicaid Act confers rights on health care providers that are

privately enforceable against the states in federal court.

As this Court recently emphasized, the text of a statute must be the focal point of any interpretive enterprise, West Virginia University Hospitals, Inc. v. Casey, ____ U.S.____, 111 S. Ct. 1138, 1148 (1991), including an analysis of whether a plaintiff has a right to sue under section 1983 when the underlying federal statute on which the claim is based does not expressly create a private cause of action. See Wright v. Roanoke Development & Housing Authority, 479 U.S. 418 (1987). Yet, as Chief Justice Rehnquist observed in dissent, in holding that providers have an enforceable substantive judicial right under the Medicaid Program, the Wilder majority "virtually ignore[d] the relevant text of the Medicaid statute in this case."

Wilder, 110 S. Ct. 2525, 2526 (Rehnquist, C.J., dissenting). Specifically, Chief Justice Rehnquist explained that:

> [t]he Medicaid statute provides for appropriations of federal funds to States that submit, and have approved by the Secretary of Health and Human Services, 'State plans for medical assistance.'. . . The next provision in the statute specifies requirements for the contents of State medical assistance plans. § 1396(a). The provision in issue here, § 1396a(a)(13)(A), is simply a part of the thirteenth listed requirement for such plans. In light of the placement of § 1396a(a)(13)(A) within the structure of the statute, . . . one most reasonably would conclude that § 1396a(a)(13)(A) is addressed to the States and merely establishes one of many conditions for receiving Federal Medicaid funds; the test does not clearly confer any substantive rights on Medicaid services providers. This structural evidence is buttressed by the absence in the statute of any express 'focus' on providers as a beneficiary class of the provision.

110 S. Ct. 2525, 2527 (Rehnquist, C.J., dissenting) (emphasis added) (citations omitted).

Simply stated, the language of the statute does not support a conclusion that Congress intended to create a substantive right enforceable by providers. Moreover, a careful review of the statute and the implementing regulations confirms that the only obligations imposed on the states concerning hospital reimbursment are to make findings and assurances to the Secretary and to obtain approval of the Secretary as a preconditon of federal funding. See 42 U.S.C. §1396a(a)(13)(A); 42 C.F.R. §§ 447.250-447.280. See also Wilder, 110 S. Ct. 2525, 2527 (Rehnquist, C.J., dissenting). Ignoring the statutory language, the Wilder majority effectively converted the Medicaid Program into an entitlement program, not for poor people but for hospitals and other health care providers.

Even if the Wilder majority correctly concluded that providers have a right to "reasonable and adequate" reimbursement, the statute simultaneously prescribes the manner in which that right may be enforced, through congressionally mandated state administrative appeals and remedies. Notwithstanding the extensive state administrative payment rate review process that is currently in place pursuant to federal statute and regulation (including plan review and approval, public comment on changes to a state's payment system, and administrative challenge to individual payment rates), the Wilder majority created yet another avenue of redress that dissatisfied providers may pursue. In doing so, the Wilder majority has made it possible for hospitals, or their associations, to launch multiple attacks

in multiple fora on state reimbursement policies. Such a result not only flies in the face of congressional intent, but undermines the ability of states to administer their medicaid programs in any type of coherent manner. Indeed, as Chief Justice Rehnquist noted, Wilder enables providers to bring section 1983 actions to avoid the statutorily mandated process rather than to implement it, with the result that rates created in accordance with the statutory process are displaced by rates established by court order. See Wilder, 110 S. Ct. 2525, 2527 (Rehnquist, C.J., dissenting).[2]

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[2] This affront to federalism and to the plain language of the act, discussed infra, is particularly evident and egregious in this case, where the respondents presented no evidence and where the district court made no findings or conclusions that Pennsylvania's payments under its federally approved state plan impede access of poor patients to inpatient hospital services. See 42 U.S.C. § 1396a(a)(13).

Although Congress intended to reduce federal oversight of state reimbursement schemes when it enacted the Boren Amendment,[3] the effect of Wilder was simply to shift this oversight from the federal bureaucracy to the federal courts. As predicted by Chief Justice Rehnquist in dissent, that effect is already being felt with alarming frequency and inevitably will have dramatic and potentially devastating repercussions upon the fiscal integrity of states which participate in the Medicaid Program. At least six states are currently facing Boren Amendment challenges from private providers who are seeking enhanced rates of reimbursement

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[3] The "Boren Amendment" was section 2173(a) of the Omnibus Budget Reconciliation Act of 1981, 95 Stat. 808, now codified at 42 U.S.C. § 1396a(a)(13)(A) and reproduced in relevant part at pp. 4-5, supra.

through the federal courts. See, e.g., Connecticut Hospital v. O'Neill, No. N-90-714 (D. Conn.); Abbeville General Hospital v. Ramsey, No. 91-356 (M.D. La.); Missouri Health Care Assoc. v. Stengler, 90-4307-CV-C-5 (W.D. Mo.); Nebraska Hospital Association v. Dept. of Social Services, 4-CV-91-3005 (D. Neb.); New Jersey Association of Health Care Facilities v. Gibbs, No. 90-1908 (D.N.J.); Illinois Hospital Association v. Edgar, No. 90 C 6394 (N.D. Ill.). At least two other states in addition to Pennsylvania, Washington and New York, already have had portions of their federally approved state plans invalidated at the behest of providers suing under section 1983. See Multicare Medical Center v. Washington, 768 F. Supp. 1349 (W.D. Wash. 1991); Pinnacle Nursing Home v. Axelrod, 928 F.2d 1306 (2d Cir. 1991). There is every reason to

believe that this Court's decision in Wilder will only embolden other providers to challenge other federally approved state plans under section 1983 and thereby increasingly shift federal oversight of state Medicaid compliance from the executive branch to the federal judiciary.

The torrent of private provider challenges which Wilder has begun to unleash can only exacerbate the present and foreseeable inability of states to meet their Medicaid funding obligations and further distort Congress' original intent to create a cooperative federal-state program in which each state was to share in the cost of paying for services to the poor "as far as practicable under the conditions" in that state. 42 U.S.C. § 1396. As the Government Accounting Office recently

reported to the Senate Committee on Finance, Medicaid outlays between 1984 and 1989 generally represented the most rapidly growing segment of state budgets. See GAO Report No. HRD-91-78, reprinted in Medicare & Medicaid Guide (CCH) ¶ 39,495 at p. 27,362 (June 25, 1991). For fiscal year 1990, Medicaid constituted 12 percent of total state expenditures, second only to 23 percent for elementary and secondary education. Id. at p. 27,369. Moreover, total Medicaid spending is growing faster than spending for education and, from 1984 to 1989, increased at a faster rate than general revenues in all state spending categories. Id. In short, the Medicaid Program is eating the states alive and may well cause them to finance future program expansions "at least in part by cutbacks in Medicaid eligibility and/or

health services for low-income people not protected by mandates." Id. In other words, access of the poor to medical care may well be jeopardized -- not enhanced -- by additional congressional eligibility and services mandates.

Viewed in this light, it is highly doubtful and indeed unimaginable that Congress intended to give private providers a power of redress under section 1983 which can only destabilize state economies further by giving federal courts ultimate authority to invalidate HCFA-approved state plans and to pass upon the adequacy of HCFA-approved rates. The likelihood of harm to states and to the integrity of federalism makes reconsideration of this Court's decision in Wilder ever more compelling.

II. THIS CASE PRESENTS AN IMPORTANT QUESTION OF FEDERAL LAW AS TO WHETHER A FEDERAL COURT CAN ATTRIBUTE TO CONGRESS AN UNSTATED INTENT TO IMPOSE ON A STATE INCREASED FUNDING OBLIGATIONS UNDER THE MEDICAID ACT.

This Court has admonished lower federal courts that in applying statutory mandates, where the statute's singular language is plain, "the sole function of the court is to enforce it according to its terms." See United States v. Ron Pair Enterprises, Inc., 489 U.S. 235, 241 (1989) (quoting Caminetti v. United States, 242 U.S. 470, 485 (1917)). This Court has especially adhered to this rule in cases, such as that presented here, involving the imposition of conditions on a state under federal law in return for the state's receipt of federal funds. In such cases, this Court has insisted that before a state can be held responsible

for funding a claimed entitlement, it must be clear that Congress imposed such a condition "unambiguously," so that a state is not left "unaware of the [grant] conditions or is unable to ascertain what is expected of it." Pennhurst State School & Hospital v. Halderman, 451 U.S. 1, 17 (1981).

Applying these principles to this case, there is no basis for the district court's finding that a state has an "obligation" to make a disproportionate share payment that is "in the same ball park as the Medicare calculation would produce." App. 99a. Whatever "ball park" the district court may have imagined itself in as the umpire, rather than applying rules which have long been established by this Court, it simply composed and applied its own rules long after the game had commenced.

Consistent with its intention to give states flexibility and discretion in the manner in which they provide Medicaid reimbursement, Congress has permitted states to calculate the required additional disproportionate share payments either by adopting the formula for payments to disproportionate share hospitals used in the Medicare program or by developing their own formulae. See 42 U.S.C. § 1396r-4. States which develop their own formulae must provide for a "minimum specified additional payment amount" that is proportionate "to the percentage by which the hospital's Medicaid utilization rate ... exceeds one standard deviation above the mean medicaid inpatient utilization rate," 42 U.S.C. § 1396r-4(c)(2), or that is "reasonably related to the costs, volume, or proportion of services provided to

patients eligible for medical assistance." 42 U.S.C. § 1396r-4(c)(3)(B).

The district court here simply assumed that "Congress seem[ed] to have contemplated that the State's plan would produce comparable results" to Medicare in the setting of these payment amounts. App. 82a. Nothing in the law or legislative history reflects such contemplation. If Congress had intended a "ball park" level of compensation, it could easily have so expressed that requirement in the statute. Instead, Congress chose not to establish any minimum amount for disproportionate share payments in those instances where a state develops its own formulae and has provided no guidance beyond the statutory language in § 1396r-4 to assist a state in developing its own formula of payment. HCFA, the agency charged with interpreting the Medicaid Act, likewise

has not adopted any rules requiring this notion of comparability. Indeed, HCFA expressly approved the State's disproportionate share payment plan.[4] Thus the State, in reliance upon the plain language of the statute itself and on the explicit approval of its disproportionate share plan by HCFA, implemented those payments and otherwise planned, administered and funded its entire Medicaid Program.

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[4] Under such circumstances, the district court should have accorded great deference to HCFA's interpretation of 42 U.S.C. §1396r-4 in approving Pennsylvania's state plan amendment for disproportionate share payments. See, e.g., Chevron, Inc. v. Natural Resources Defense Council, 467 U.S. 837, 843 (1984); Gladstone, Realtors v. Village of Bellmead, 441 U.S. 91, 107 (1979).

The lower courts' judicially imposed funding requirement of comparability is also at odds with, and contrary to, recent congressional review of the disproportionate share concept. In October 1990, Senators Riegle and Chafee introduced a bill which would have for the first time imposed on the states "a uniform national minimum disproportionate share adjustment, equal at least to the amount of the adjustment that would result from using the Medicare adjustment formula" under section 1923(c) of the Act. See Senate Bill No. 3265 and Senator Riegle's comments at 136 Cong. Rec. S17866-17867 (October 27, 1990). That bill did not become law. Nevertheless, at respondents' urging, the courts below engrafted just such a requirement onto the otherwise plain language of section 1396r-4 of the Act,

thereby requiring Pennsylvania to pay disproportionate share adjustments at or near Medicare levels.

This Court should not countenance such judicial legislation, especially where, as here, the danger of permitting other courts to replicate such a precedent not only subverts congressional will but dramatically alters the nature of the bargain struck by Congress and the states under Medicaid's exercise in "cooperative federalism." As a participant in Medicaid, Pennsylvania has complied with, and funded, numerous major mandatory (as well as most optional) expansions of the program that have been passed by Congress between 1984 and 1990, which are set out in Appendix I to the GAO report, supra. As noted by the General Accounting Office, during this same period, Medicaid expenditures rose at an average annual rate of 10 percent

while total state revenues increased at a rate below 8 percent. See GAO Report No. HRD-91-78, reprinted in Medicare & Medicaid Guide (CCH) ¶ 39,495 at p. 27,357 (June 25, 1991). What this Court must address, consistent with its prior case law, is the imposition by judicial fiat of a mandate that Pennsylvania did not voluntarily and knowingly accept as a term of its contract with the federal government under the Medicaid program. This Court must not permit a lower court to attribute to Congress an unstated intent and so create an enforceable entitlement which compels a state to expend funds under a federal-state grant program where the state neither knew nor reasonably could have known that such an entitlement exists.

For all of these reasons, this Court should reject the district court's conclusions concerning disproportionate share payments, which were affirmed without specific discussion by the Court of Appeals.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for the writ of certiorari and, upon review, vacate or reverse the decision of the Court of Appeals.

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Filed July 30, 1991

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 90-1112

TEMPLE UNIVERSITY

Plaintiff - Appellee

v.

JOHN F. WHITE, JR.; EILEEN M. SCHOEN; DAVID S. FEINBERG; DAVID D. ULSH; G. JUNE HOCH

Defendants - Appellants

No. 90-1203

ALBERT EINSTEIN MEDICAL CENTER, ALLEGHENY GENERAL HOSPITAL, CHILDREN'S HOSPITAL OF PITTSBURGH, EPISCOPAL HOSPITAL, GIUFFRE MEDICAL CENTER, MAGEE-WOMENS HOSPITAL, MERCY CATHOLIC MEDICAL CENTER-MISERICORDIA DIVISION, MERCY HOSPITAL OF PITTSBURGH, MONTEFIORE HOSPITAL ASSOCIATION OF WESTERN PENNSYLVANIA, INC., PRESBYTERIAN UNIVERSITY HOSPITAL OF PITTSBURGH, ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN, ST. JOSEPH'S HOSPITAL, ST. MARY HOSPITAL, WESTERN

PENNSYLVANIA HOSPITAL, GERMANTOWN HOSPITAL AND MEDICAL CENTER

v.

WHITE, JOHN F., JR., as Secretary of Public Welfare, HERSHOCK, MICHAEL H., as Secretary of the Budget

John F. White, Jr. and Michael H. Hershock,

Appellants

No. 90-1204

FRANKFORD HOSPITAL

v.

WHITE, JR., JOHN F., Secretary of Public Welfare, SCHOEN, EILEEN M., Deputy Secretary for Medical Assistance, Programs, FEINBERG, DAVID S., Director of the Bureau of Policy and Program Development of the Office of Medical Assistance, Programs, ULSH, DAVID D., Acting Director of the Division of Inpatient Programs of the Office of Medical Assistance Programs, and HERSHOCK, MICHAEL H., Secretary of the Budget

John F. White, Jr., Eileen M. Schoen, David S. Feinberg, David D. Ulsh and Michael H. Hershock,

Appellants

No. 90-1205

HAHNEMANN UNIVERSITY HOSPITAL and PRESBYTERIAN MEDICAL CENTER OF PHILADELPHIA, and THE TRUSTEES OF UNIVERSITY OF PENNSYLVANIA

v.

WHITE, JOHN F., JR., Secretary of Public Welfare, SCHOEN, EILEEN M., Deputy Secretary for Medical Assistance, FEINBERG, DAVID S., Director of the Bureau of Policy and Program Development of the Office of Medical Assistance, and ULSH, DAVID D., Acting Director of the Division of Inpatient Programs of the Office of Medical Assistance and HERSHOCK, MICHAEL H., Secretary of the Budget

John F. White, Jr., Eileen M. Schoen, David S. Feinberg, David D. Ulsh, and Michael H. Hershock,

Appellants

No. 90-1206

HOSPITAL ASSOCIATION OF PENNSYLVANIA; ALLEGHENY VALLEY HOSPITAL; THE ALLENTOWN HOSPITAL; ALLENTOWN OSTEOPATHIC MEDICAL CENTER; J.C. BLAIR MEMORIAL HOSPITAL; BRADDOCK GENERAL HOSPITAL; BRADFORD HOSPITAL;

BRANDYWINE HOSPITAL; BUTLER MEMORIAL HOSPITAL; CARBONDALE GENERAL HOSPITAL; CENTRAL MEDICAL CENTER AND HOSPITAL; CHAMBERSBURG HOSPITAL; CHESTER COUNTY HOSPITAL; CHESTNUT HILL HOSPITAL; THE CHILDREN'S HOSPITAL OF PHILADELPHIA; CHARLES COLE MEMORIAL HOSPITAL; CLARION OSTEOPATHIC COMMUNITY HOSPITAL; CLEARFIELD HOSPITAL; COMMUNITY GENERAL OSTEOPATHIC HOSPITAL; COMMUNITY MEDICAL CENTER; CONEMAUGH VALLEY MEMORIAL HOSPITAL; DIVINE PROVIDENCE HOSPITAL; DIVINE PROVIDENCE HOSPITAL OF PITTSBURGH; DOYLESTOWN HOSPITAL; DUBOIS REGIONAL MEDICAL CENTER; EPHRATA COMMUNITY HOSPITAL; EVANGELICAL COMMUNITY HOSPITAL; EYE & EAR HOSPITAL OF PITTSBURGH; FORBES METROPOLITAN HEALTH CENTER; FORBES REGIONAL HEALTH CENTER; FRANKLIN REGIONAL MEDICAL CENTER; FRICK COMMUNITY HEALTH CENTER; GEISINGER MEDICAL CENTER; GEISINGER WYOMING VALLEY MEDICAL; THE GERMANTOWN HOSPITAL AND MEDICAL CENTER; GETTYSBURG HOSPITAL; GNADEN HUETTEN MEMORIAL HOSPITAL; GOOD SAMARITAN HOSPITAL; GREENE COUNTY MEMORIAL HOSPITAL; HAMOT MEDICAL CENTER; HANOVER GENERAL HOSPITAL; HARRISBURG HOSPITAL; HIGHLANDS HOSPITAL AND HEALTH CENTER; INDIANA HOSPITAL; HAMESON MEMORIAL HOSPITAL; JEANNETTE DISTRICT MEMORIAL HOSPITAL; JEFFERSON HOSPITAL; ANDREW KAUL MEMORIAL

HOSPITAL; KENSINGTON HOSPITAL; LANCASTER GENERAL HOSPITAL; LANKENAU HOSPITAL; LEE HOSPITAL; LEHIGH VALLEY HOSPITAL CENTER; McKEESPORT HOSPITAL; MEADVILLE MEDICAL CENTER; THE MEDICAL CENTER, BEAVER, PA., INC.; MEDICAL COLLEGE OF PENNSYLVANIA; MEMORIAL HOSPITAL; MEMORIAL HOSPITAL OF BEDFORD; MERCY CATHOLIC MEDICAL CENTER, FITZGERALD MERCY DIVISION; MERCY HOSPITAL, ALTOONA; MERCY HOSPITAL, SCRANTON; METHODIST HOSPITAL; MILLCREEK COMMUNITY HOSPITAL; MONONGAHELA VALLEY HOSPITAL; MUHLENBURG HOSPITAL CENTER; NESBITT MEMORIAL HOSPITAL; NORTHEASTERN HOSPITAL OF PHILADELPHIA; NORTH PENN HOSPITAL; OSTEOPATHIC MEDICAL CENTER OF PHILADELPHIA; PENNSYLVANIA HOSPITAL; PHOENIXVILLE HOSPITAL; POTTSTOWN MEMORIAL MEDICAL CENTER; POTTSVILLE HOSPITAL AND WARNE CLINIC; PUNXSUTAWNEY AREA HOSPITAL; THE PENN STATE HOSPITAL/THE MILTON S. HERSHEY MEDICAL CENTER; QUAKERTOWN COMMUNITY HOSPITAL; READING HOSPITAL AND MEDICAL CENTER; ROXBOROUGH MEMORIAL HOSPITAL; ST. AGNES MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST JOSEPH'S HOSPITAL, CARBONDALE; ST. JOSEPH HOSPITAL, LANCASTER; SACRED HEART HOSPITAL; SEWICKLEY VALLEY HOSPITAL; SHADYSIDE HOSPITAL; SHARON GENERAL HOSPITAL; THE SOUTH SIDE HOSPITAL; SOUTHERN CHESTER COUNTY MEDICAL CENTER; SUBURBAN GENERAL HOSPITAL; SUNBURY COMMUNITY

HOSPITAL; TAYLOR HOSPITAL; TYLER MEMORIAL HOSPITAL; TYRONE HOSPITAL; WESTMORELAND HOSPITAL ASSOCIATION; WILKES-BARRE GENERAL HOSPITAL; THE WILLIAMSPORT HOSPITAL & MEDICAL CENTER; and YORK HOSPITAL AND GREENVILLE REGIONAL HOSPITAL

v.

WHITE, JOHN F., JR., as Secretary of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania;
HERSHOCK, MICHAEL H., in his official capacity only as Secretary of the Budget, Department of the Budget, Commonwealth of Pennsylvania;
FRANKLIN, CAROLYN, in her official capacity only as Western Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania;
HUGHES, PATRICIA, in her offical capacity only as Southeastern Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania

John F. White, Jr., Carolyn Franklin, Patricia Hughes and Michael H. Hershock,

Appellants

No. 90-1244

TEMPLE UNIVERSITY

Plaintiff - Appellee

v.

JOHN F. WHITE, JR.; EILEEN M. SCHOEN; DAVID S. FEINBERG; DAVID D. ULSH; G. JUNE HOCH

Defendants - Appellants

No. 90-1661

HOSPITAL ASSOCIATION OF PENNSYLVANIA; ALLEGHENY VALLEY HOSPITAL; THE ALLENTOWN HOSPITAL; ALLENTOWN OSTEOPATHIC MEDICAL CENTER; J.C. BLAIR MEMORIAL HOSPITAL; BRADDOCK GENERAL HOSPITAL; BRADFORD HOSPITAL; BRANDYWINE HOSPITAL; BUTLER MEMORIAL HOSPITAL; CARBONDALE GENERAL HOSPITAL; CENTRAL MEDICAL CENTER AND HOSPITAL; CHAMBERSBURG HOSPITAL; CHESTER COUNTY HOSPITAL; CHESTNUT HILL HOSPITAL; THE CHILDREN'S HOSPITAL OF PHILADELPHIA; CHARLES COLE MEMORIAL HOSPITAL; CLARION OSTEOPATHIC COMMUNITY HOSPITAL; CLEARFIELD HOSPITAL; COMMUNITY GENERAL OSTEOPATHIC HOSPITAL; COMMUNITY MEDICAL CENTER; CONEMAUGH VALLEY MEMORIAL HOSPITAL; DIVINE PROVIDENCE HOSPITAL; DIVINE PROVIDENCE HOSPITAL OF PITTSBURGH; DOYLESTOWN HOSPITAL; DUBOIS REGIONAL MEDICAL CENTER; EPHRATA COMMUNITY HOSPITAL; EVANGELICAL COMMUNITY HOSPITAL; EYE & EAR HOSPITAL OF PITTSBURGH; FORBES

METROPOLITAN HEALTH CENTER; FORBES REGIONAL HEALTH CENTER; FRANKLIN REGIONAL MEDICAL CENTER; FRICK COMMUNITY HEALTH CENTER; GEISINGER MEDICAL CENTER; GEISINGER WYOMING VALLEY MEDICAL CENTER; THE GERMANTOWN HOSPITAL AND MEDICAL CENTER; GETTYSBURG HOSPITAL; GNADEN HUETTEN MEMORIAL HOSPITAL; GOOD SAMARITAN HOSPITAL; GREENE COUNTY MEMORIAL HOSPITAL; HAMOT MEDICAL CENTER; HANOVER GENERAL HOSPITAL; HARRISBURG HOSPITAL; HIGHLANDS HOSPITAL AND HEALTH CENTER; INDIANA HOSPITAL; HAMESON MEMORIAL HOSPITAL; JEANNETTE DISTRICT MEMORIAL HOSPITAL; JEFFERSON HOSPITAL; ANDREW KAUL MEMORIAL HOSPITAL; KENSINGTON HOSPITAL; LANCASTER GENERAL HOSPITAL; LANKENAU HOSPITAL; LEE HOSPITAL; LEHIGH VALLEY HOSPITAL CENTER; McKEESPORT HOSPITAL; MEADVILLE MEDICAL CENTER; THE MEDICAL CENTER, BEAVER, PA., INC.; MEDICAL COLLEGE OF PENNSYLVANIA; MEMORIAL HOSPITAL; MEMORIAL HOSPITAL OF BEDFORD; MERCY CATHOLIC MEDICAL CENTER, FITZGERALD MERCY DIVISION; MERCY HOSPITAL, ALTOONA; MERCY HOSPITAL, SCRANTON; METHODIST HOSPITAL; MILLCREEK COMMUNITY HOSPITAL; MONONGAHELA VALLEY HOSPITAL; MUHLENBURG HOSPITAL CENTER; NESBITT MEMORIAL HOSPITAL; NORTHEASTERN HOSPITAL OF PHILADELPHIA; NORTH PENN HOSPITAL; OSTEOPATHIC MEDICAL CENTER OF PHILADELPHIA; PENNSYLVANIA HOSPITAL;

PHOENIXVILLE HOSPITAL; POTTSTOWN MEMORIAL MEDICAL CENTER; POTTSVILLE HOSPITAL AND WARNE CLINIC; PUNXSUTAWNEY AREA HOSPITAL; THE PENN STATE HOSPITAL/THE MILTON S. HERSHEY MEDICAL CENTER; QUAKERTOWN COMMUNITY HOSPITAL; READING HOSPITAL AND MEDICAL CENTER; ROXBOROUGH MEMORIAL HOSPITAL; ST. AGNES MEDICAL CENTER; ST. FRANCIS MEDICAL CENTER; ST. JOSEPH'S HOSPITAL, CARBONDALE; ST. JOSEPH HOSPITAL, LANCASTER; SACRED HEART HOSPITAL; SEWICKLEY VALLEY HOSPITAL; SHADYSIDE HOSPITAL; SHARON GENERAL HOSPITAL; THE SOUTH SIDE HOSPITAL; SOUTHERN CHESTER COUNTY MEDICAL CENTER; SUBURBAN GENERAL HOSPITAL; SUNBURY COMMUNITY HOSPITAL; TAYLOR HOSPITAL; TYLER MEMORIAL HOSPITAL; TYRONE HOSPITAL; WESTMORELAND HOSPITAL ASSOCIATION; WILKES-BARRE GENERAL HOSPITAL; THE WILLIAMSPORT HOSPITAL & MEDICAL CENTER; and YORK HOSPITAL and GREENVILLE REGIONAL HOSPITAL

v.

WHITE, JOHN F., JR., as Secretary of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania
HERSHOCK, MICHAEL H., in his official capacity only as Secretary of the Budget, Department of the Budget, Commonwealth of Pennsylvania
FRANKLIN, CAROLYN, in her official capacity only as Western Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania

HUGHES, PATRICIA, in her official capacity only as Southeastern Regional Representative of Public Welfare, Department of Public Welfare, Commonwealth of Pennsylvania

John F. White, Jr., Carolyn Franklin, Patricia Hughes and Michael H. Hershock,

Appellants

On Appeal from the United States District Court for the Eastern District of Pennsylvania (D.C. Nos. 88-06646, 88-08831, 88-08927, 88-09132, 88-09848, 88-06646 and 88-09848)

Argued Thursday, January 10, 1991

BEFORE: COWEN, ALITO and GARTH, *Circuit Judges*

(Opinion filed July 30, 1991)

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OPINION OF THE COURT

GARTH, *Circuit Judge*:

This set of six consolidated appeals arises from the challenges, raised by over 140 Pennsylvania hospitals, to the validity of Pennsylvania's payment rates that the Commonwealth has set pursuant to its obligations under the Medicaid Program, Title XIX of the Social Security Act. 42 U.S.C.A. § 1396 *et seq.* (1983 & West Supp. 1991). The Medicaid Program, as it is described in *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306, 1309 (2d Cir. 1991), "establishes a joint federal and state cost-sharing system to provide necessary medical services to indigent persons who otherwise would be unable to afford such care."

Because Pennsylvania participates in the Medicaid Program, it must comply with the federal statutory and regulatory scheme which requires, among other things, that a participating state establish a Medical Assistance Program, ("MAP"), pursuant to which it pays hospitals for their inpatient treatment of Medicaid patients. *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2513 (1990). The hospitals involved in these appeals all claim that Pennsylvania's 1988-1989 payment rates were inadequate to meet the substantive standards of Title XIX, and that the method by which the Commonwealth promulgated those rates did not comply with the requirements of that statute. Accordingly, the plaintiff hospitals argue that Pennsylvania's MAP, which established the 1988-1989 rates, must be voided.

I

Temple University, ("Temple"), brought this § 1983 action in August of 1988, alleging that the Pennsylvania Department of Public Welfare, ("DPW"), was depriving Temple University Hospital of rights secured by Title XIX, 42 U.S.C.A. § 1396 *et seq.*, and the regulations thereunder.[1] Following a bench trial, the district court issued an opinion on January 24, 1990, holding that: (1) the Pennsylvania MAP payment rates were arbitrary because the procedure by which DPW grouped the hospitals for rate classification was unrelated to the efficiency or economy of the hospitals, and because Pennsylvania's across-the-board "budget neutrality" cut was entirely budget-driven and not justifiable; (2) the 2.5% add-on that DPW granted Temple for its status as a disproportionate-share hospital[2] was inadequate in light of the federal statutory requirement that Pennsylvania's MAP take into account the special circumstances of hospitals treating a disproportionate number of low-income patients; and (3) the process by which DPW adopted its MAP and rates did not comply with the federal statutory and regulatory

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1. Any doubt that § 1396a(a)(13)(A) creates rights enforceable under § 1983 was laid to rest by the Supreme Court's ruling in *Wilder v. Virginia Hospital Ass'n*, 110 S. Ct. 2510 (1990). *Wilder* held, among other things, that § 1983 does provide a cause of action for the substantive rights established in § 1396a(a)(13)(A).

2. A disproportionate-share hospital is one that, pursuant to statute, is entitled to receive additional payments because of its service to a disproportionate number of low income patients. *See infra* § II B (citing 42 U.S.C.A. § 1396r-4(b) (West Supp. 1991)).

requirements mandating that each participating state make meaningful findings as to the reasonableness and adequacy of the rates established and as to the State's add-ons for a hospital's disproportionate-share status. *See Temple University v. White*, 729 F. Supp. 1093, 1096-1101 (E.D. Pa. 1990). The district court accordingly ordered DPW to bring the Pennsylvania MAP into conformity with federal requirements, and ordered further briefing as to the appropriate level of interim payments pending modification of the MAP. *Temple*, 729 F. Supp. at 1101.

On February 21, 1990, the district court awarded interim relief to Temple to mitigate the irreparable loss that Temple would otherwise suffer pending DPW's development of a new MAP. *Temple University v. White*, 732 F. Supp. 1327, 1328 (E.D. Pa. 1990). The district court established the interim payment rate by restructuring the group into which Temple had been placed to include only the seven most similar hospitals. The court also reduced the arbitrary "budget neutrality" adjustment from 14% to 2.4%, and raised the disproportionate share add-on to 10%. *Id.* at 1328-29. The district court ordered that "pending final revision of its Medicaid plan . . . [DPW] shall, with respect to all of plaintiff's bills paid on or after January 25, 1990, utilize a payment rate of $3,643.09." (App. 31).[3] *See also Temple*, 732 F.

3. Citations to "(App.)" refer to the Appendix filed with this court by the appellants on March 26, 1990. Citations to "(Supp. App.)" refer to the Supplemental Appendix filed by the appellants on May 9, 1990. Citations to "(SH App.)" refer to the Appendix filed in case No. 90-1661, in relation to the award of emergency relief to Sacred Heart Hospital. *See infra* § V. Citations to "(SH Supp. App.)" refer to the Supplemental Appendix filed by the Appellees along with their brief in No. 90-1661 on November 21, 1990.

Supp. at 1329. The district court did not require Temple to post a bond because of the ongoing relationship between the parties and the ability of DPW to recapture any excessive payments through reductions in future payments, if necessary. *Id.*

Meanwhile, the other hospitals involved in this appeal had filed similar suits against DPW, seeking essentially the same relief as Temple had sought. The district court entered its January 24 and February 21, 1990 orders in the Temple case while those cases were pending. Subsequently, the other hospitals filed various motions for interim relief, and, on March 1, 1990, the district court entered an order granting relief in each of those pending cases.[4] The court granted relief "for the reasons stated in this court's rulings on interim relief in [*Temple*] (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features)." *See supra* note 4. The orders required DPW to apply a rate calculation in its payments to the hospitals that did not include any "budget neutrality" adjustment in excess of 2.4%, *id.*, the amount the court imposed in the *Temple* case after invalidating the 14% across-the-board cut as being arbitrary and solely budget-driven. 732 F. Supp. at 1328-29.

Subsequently, in August, 1990, while these cases were pending on appeal, Sacred Heart

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4. *Albert Einstein Medical Center v. White*, 732 F. Supp. 1329 (E.D. Pa. 1990); *Frankford Hosp. v. White*, unpublished order, No. 88-8927 (E.D. Pa. March 1, 1990); *Hahnemann University Hosp. v. White*, unpublished order, No. 88-9132 (E.D. Pa. March 1, 1990); *Hosp. Ass'n of Pennsylvania v. White*, unpublished order, No. 88-9848 (E.D. Pa. March 1, 1990). The district court entered an identical order in each of these cases. See *infra* note 14 for the full text of these orders.

Hospital, a party to the *Hospital Association of Pennsylvania* case, filed an application with the district court, seeking emergency relief. Sacred Heart sought a $2 million advance from DPW against amounts expected as future payments for medical assistance under the MAP that DPW had been directed to promulgate. At the close of an August 14, 1990 hearing, the district court granted relief to Sacred Heart by entering a preliminary injunction requiring DPW to advance to Sacred Heart a total of $2 million to be paid in installments of $500,000, beginning ten days after the date of its Order and continuing thereafter at 30-day intervals. Transcript of Hearing of August 14, 1990 at 139; (SH App. 155). On October 5, 1990, the district court denied DPW's motion for a stay of this injunctive relief. *See Hosp. Ass'n of Pennsylvania v. White*, Unpublished Order, No. 88-9848 (E.D. Pa. October 15, 1990); (SH Supp. App. 3-6).[5]

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5. After oral argument, but before the filing of this opinion, we were informed that the parties had executed and filed, with the district court, a comprehensive document entitled "Stipulation of Settlement." In addition, Sacred Heart informed us that a special agreement had been entered into and filed with respect to its appeal at No. 90-1661. Supplemental submissions were then filed by the parties with this court addressed to the issue of possible mootness. We were advised of the highly conditional nature of the settlement, *see Coopers & Lybrand v. Livesay*, 437 U.S. 463, 465 n.3 (1978), and were furnished with copies of the Stipulation of Settlement and the special Sacred Heart agreement.

We have supplemented the record on these appeals with these documents, and we have noted the various obligations placed upon the parties, compliance with which is required for each of the fiscal years, to and including June, 1993, at which date, if all terms have been met, the parties have agreed that the actions be dismissed. Prior to that time,

II

A

The Medicaid law, Title XIX of the Social Security Act, 42 U.S.C.A. § 1396 *et seq.*, authorizes federal financial support to states providing medical assistance to certain low income persons. In Pennsylvania, the federal financial contribution amounts to 56% of the costs of covered services. *Temple*, 732 F. Supp. at 1327-28.[6] Participation in Medicaid is optional, but once a state elects to participate, it must comply with all federal statutory and regulatory requirements. *Wilder*, 110 S. Ct. at 2513; *Harris v. McCrae*, 448 U.S. 297, 301 (1980).

States have historically paid hospitals the actual costs incurred in providing care to Medicaid recipients, regardless of disparities in costs or efficiencies among the respective hospitals. In 1981, Congress enacted the "Boren Amendment,"

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the Stipulation contemplates that DPW will make payments to the hospitals that exceed those which are required by the district court orders we review here.

We are satisfied that these appeals have not been mooted by the Stipulation and agreements of the parties, *see, e.g.*, Stipulation of Settlement p. 33, ¶ 6.5, and that disposition of the instant appeals should be had on the merits. *See Coopers & Lybrand*, 437 U.S. at 465 n.3. We, of course, express no view concerning the approval of the Stipulation of Settlement and the Sacred Heart agreement by the district court, inasmuch as neither the terms of the agreements nor their approval are the subjects of appeal before us.

6. See *West Virginia University Hosp. v. Casey*, 885 F.2d 11, 15 (3d Cir. 1989), *aff'd in part*, 111 S. Ct. 1138 (1991) (Court reviewed and affirmed only an issue as to attorneys' fees) [hereinafter "*WVUH*"], for a more detailed overview of Title XIX.

see 42 U.S.C.A. § 1396a(a)(13)(A), which substituted for this mandatory "reasonable cost reimbursement" system the requirement that states must at least provide payments to hospitals:

> through the use of rates (determined in accordance with methods and standards developed by the State . . . and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . .) which the State *finds*, and makes assurances satisfactory to the Secretary, are *reasonable and adequate* to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality[.]

42 U.S.C.A. § 1396a(a)(13)(A) (emphasis added).

To qualify for federal funding, a state must submit a state plan - a MAP - for approval by the Health Care Financing Administration ("HCFA"), of the Department of Health and Human Services. 42 C.F.R. § 447.200 (1990). The MAP must "specify comprehensively the methods and standards used by the agency to set payment rates," 42 C.F.R. § 447.252(b); provide for the payment of rates which the state "finds" are "reasonable and adequate" to "meet the costs that must be incurred by economically and efficiently operated facilities," 42 C.F.R. § 447.253(b); and contain "assurances" to HCFA that this standard has been satisfied. 42

C.F.R. § 447.253(a). HCFA relies on the state's "assurances" and does not independently evaluate the adequacy of the rates. At least annually, a state must make "findings" that assure the "reasonableness and adequacy" of its inpatient hospital rates. 42 C.F.R. § 447.253(b). It must also make findings "[w]henever the Medicaid agency makes a change in its methods and standards." *Id.*

B

Through the fiscal year ending on June 30, 1984, the Pennsylvania MAP reimbursed hospitals based on their actual costs. In 1984, DPW, relying on the Boren Amendment, promulgated a revised MAP that provided for a change to a prospective payment system. (Supp. App. 446a).[7] Under that system, the operating costs of most acute care inpatient hospital stays are reimbursed by a flat payment per discharge that is a multiple of the hospital's "payment rate" and a "relative value" assigned to the diagnostic related group ("DRG") into which the particular case falls.

A hospital's payment rate depends on its peer "Group" category. DPW ranks all general hospitals (with the exception of children's hospitals), into seven approximately equally sized Groups based upon weighted ratings in each of four categories with the aim of roughly aligning hospitals with similar characteristics. *See* (Supp. App. 498a-501a). Each children's hospital comprises its

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7. See *WVUH*, 885 F.2d at 15-16 and *Temple University v. White*, 729 F. Supp. 1093, 1095-99 (E.D. Pa. 1990), for a more detailed description of Pennsylvania's prospective payment system.

own Group. Hospitals in Groups 1 and 2 and children's hospitals treat the largest volume of Medicaid recipients in the Commonwealth, and are, therefore, the most heavily dependent on MAP revenues to meet operating costs. (Supp. App. 603a-04a). Group payment rates are based on the weighted group average cost per case within each group that DPW derives through a detailed computation. (App. 60-62); *Temple*, 729 F. Supp. at 1097.

Some hospitals also receive additional payments because of their service to a disproportionate number of low income patients. Pursuant to the statutory requirements, 42 U.S.C.A. § 1396r-4(b), DPW identified these disproportionate-share status hospitals, then arranged these hospitals into five groups defined by the percentage of their total days devoted to federally funded medical assistance patients. Hospitals in these five disproportionate share groups receive additional payments of .5%, 1%, 1.5%, 2%, or 2.5% above their regular payment rates.

For 1984, the first year that the prospective payment plan was operative, DPW structured the system to be "budget neutral," and applied an adjustment factor to limit aggregate payments to an estimate of what the old system's payments would have been. (Supp. App. 465a). After the regrouping of hospitals into their assigned groups pursuant to DPW's 1988-1989 MAP, DPW reduced the group average rates for all Groups by a uniform factor of approximately 14% to effect what DPW called a "budget neutrality adjustment." This 14% "lop off," (Supp. App. 568a-69a, 572a), was designed to restrict total MAP payments to the

respective hospitals to the amount of the total inpatient budget appropriation for 1988-1989.[8]

III

Title XIX requires states to set rates "which the State *finds*, and makes assurances satisfactory to the Secretary, are *reasonable and adequate* to meet the costs which must be incurred by efficiently and economically operated facilities. . . ." 42 U.S.C.A. § 1396a(a)(13)(A) (emphasis added). We held, in *WVUH*, that the federal regulations implementing § 1396a(a)(13)(A) "unambiguously require the State to make findings" to support its Medicaid plan. 885 F.2d at 30.[9] In so holding, we determined that

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8. By applying the 14% budget neutrality adjustment, the budget was reduced to $427 million from $497 million, the budget amount that otherwise would have been available. (App. 505); (Supp. App. 646a).

9. Federal regulations specify that:

> (b) *Findings*. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:
>
> (1) *Payment Rates*. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
>
> (ii) With respect to inpatient hospital services-
>
> (A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. . . .

42 C.F.R. § 447.253(b) (1990).

Pennsylvania was not in compliance with the federal statute and regulations because it admitted to gathering no information as to the out-of-state hospitals' actual costs, and did no empirical analysis to measure the effects of the payment program on those hospitals and thus made none of the requisite findings. *Id.* at 30. The Supreme Court recently took note of this "findings" requirement in *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510, 2519 & n.11 (1990). In response to an argument that Title XIX merely required that a state provide assurances to the Secretary that its rates comply with the statute, the Court emphasized that such an argument "ignores the language of the statute that requires a State to *find* that its rates" comply with the reasonable and adequate requirement, and that such findings are "a necessary prerequisite to the subsequent requirement that the State provide 'assurances' to the Secretary." *Id.* at 2519 n.11 (emphasis in original).[10] We review the issue of a state's compliance with Title XIX's procedural requirements under a plenary standard. *See WVUH*, 885 F.2d at 29-30.

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10. *See also AMISUB v. State of Colorado Dep't of Social Services*, 879 F.2d 789, 796 (10th Cir. 1989) (holding that "[t]he plain language of federal Medicaid law mandates the State Medicaid Agency, *at a minimum*, to make 'findings' which identify and determine (1) efficiently and economically operated hospitals; (2) the costs that must be incurred by such hospitals; and, (3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals.") (emphasis in original), *cert. denied*, 110 S. Ct. 3212 (1990); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1294 (8th Cir. 1985) (state must conduct objective analysis or study to support its findings and assurances), *cert. denied*, 479 U.S. 1063 (1987).

More recently, the Second Circuit, in *Pinnacle Nursing Home*, addressed the procedural requirements of the Boren Amendment in the same context as we do here. 928 F.2d at 1313-14. The language of the *Pinnacle* opinion, referring to the need for findings, bears repetition:

> We decline the state's invitation to read the procedural requirements of the Boren Amendment as mere surplusage. The Supreme Court recently dispelled this notion, reconfirming that the procedural requirements of the Boren Amendment were intended to be observed. . . . In light of the abundant evidence demonstrating that Congress intended that the procedural requirements be followed, the state's argument that "findings" are not mandatory is fatally flawed. That conclusion is reinforced by the mandatory, rather than precatory, language of the statute itself. 42 U.S.C. § 1396a(a)(13)(A) ("[a] State plan for medical assistance *must*" provide for payment of rates which the state *finds* are reasonable and adequate (emphasis added)). Although procedural requirements may reduce some of the state's "flexibility" in determining their own schemes of reimbursement, this is what the plain language of the statute requires.

Pinnacle Nursing Home, 928 F.2d at 1313-14.[11]

In the present case, then, DPW was required to

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11. *Pinnacle* dealt with nursing homes that challenged adjustments made by the State of New York in connection with Medicaid reimbursements. Among other things, the Court of Appeals held that the adjustments to the Medicaid reimbursement plan were invalid because no findings were made which established a nexus between the cost of operating efficient and economical nursing facilities and the proposed reimbursement rates. *Pinnacle Nursing Home*, 928 F.2d at 1314-15.

find that its MAP complied with the three substantive requirements of § 1396a, *i.e.*, that (1) its rates take into account the circumstances of hospitals serving a disproportionate share of low-income patients; (2) its "rates are reasonable and adequate to meet the necessary costs of an efficiently operated hospital;" and (3) its rates are reasonable and adequate "to assure medicaid patients of reasonable access to inpatient hospital care." *WVUH*, 885 F.2d at 22.

The district court, however, found that DPW made no findings based upon empirical studies "on such matters, for example, as the characteristics of an efficient and economical hospital operation, the impact of the proposed reimbursement rates upon hospitals' ability to survive, etc. – but merely certified that its plan complied with the statutory requirements." *Temple*, 729 F. Supp. at 1100. DPW's study or investigation of its rate structure was limited to a few internally-generated reports that show which hospitals reported costs above or below the group rates and to some revenue projections indicating that, after the regrouping of the hospitals and the recalculation of the rates, the projected revenues of some of the hospitals went up and the projected revenues of the other hospitals went down. (App. 327-29). DPW also took note of the fact that it had not received complaints about the inability of medical assistance recipients to obtain care. (App. 328).

Thus, DPW had conducted no analysis and had made no findings as to the reasonableness or adequacy of its rates to cover the costs of an efficiently and economically operated hospital or to account for the impact on a hospital of its across-the-board budget neutrality adjustment and

varying percentage add-ons for disproportionate-share hospitals. Nor did DPW identify any findings which it made pertaining to "reasonable access to inpatient hospital care." Indeed, DPW admitted as much during pretrial discovery. Temple posed the following interrogatory:

> Identify any studies performed, findings prepared, or investigations conducted by DPW referring or relating to or evidencing the adequacy and reasonableness of the M.A. Program's inpatient hospital rates relative to costs for Fiscal Year 1989 (using Fiscal Year 1987 claims paid data Trended Forward for Inflation and without a Budget Neutrality Adjustment).

(App. 611). DPW's answer was:

> No special studies, findings, or investigations were conducted by DPW referring or relating to or evidencing the adequacy and reasonableness of the MA Program's inpatient hospital rates relative to costs for FY 1989 (using FY 1987 claims paid data trended forward for inflation and without a Budget Neutrality Adjustment).

Id. DPW's failure to assemble information in making its decisions as to rates is reflected in the testimony of David Feinberg, an administrator in DPW responsible for "all medical assistance policy and other activities related to all inpatient hospital and outpatient providers who participate in medical assistance programs." (App. 298). Mr. Feinberg stated that "[w]e don't know, today, what hospital costs are. They have not been audited, so we don't know how close anybody is to [the various group rates]." (App. 312).

Without knowledge of hospital costs, DPW could not have known what an efficient and economical hospital operation would entail, let alone what payment rates would be reasonable and adequate to meet that hospital's costs and assure reasonable access to hospital care. In the absence of essential data and information, DPW was in no position to make findings, and clearly did not do so. Any assurances DPW made to the Secretary were, therefore, without foundation. Accordingly, as the district court held, DPW's MAP was not in compliance with federal law, specifically, § 1396a(a)(13)(A) and 42 C.F.R. § 447.253(b), as interpreted by our court and by the Supreme Court. *See WVUH*, 885 F.2d at 29-30; *Wilder*, 110 S. Ct. at 2519 & n.11.[12]

The lack of critical and required findings mandates that we affirm the district court's holding that DPW's 1988-1989 MAP was invalid, and that DPW must promulgate a new MAP that complies with the procedural and substantive provisions of Title XIX. In accordance with the remedy that we afforded to West Virginia University Hospital, "[r]eimbursement to [Temple] under a prospective payment system that conforms to federal law will commence with the date of the district court's initial judgment in this matter."

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12. At oral argument, counsel for DPW insisted repeatedly that DPW had made findings in compliance with this requirement. Despite persistent questioning from the court, however, counsel failed to point to a single specific finding in the record that would satisfy DPW's obligations. Neither have we found such a finding in the documents and testimony to which counsel referred us on this point. *See, e.g.*, Transcript of Oral Argument of January 10, 1991 at 6-16. *See also id.* at 82. Counsel subsequently conceded outright that DPW had no "written findings." *Id.* at 86.

WVUH, 885 F.2d at 35. Any adjustment that becomes necessary as to the amount of the payments to be made to Temple pursuant to the district court's injunction is to be made either through additional DPW payments to Temple or by DPW's recoupment in future payments of any overpayments.

IV

A

DPW challenges the "interim" injunctive relief that the district court awarded to Temple in its February 21, 1990 order,[13] and to the other hospitals, (hereinafter referred to as "Hospitals"), in its March 1, 1990 orders.[14] As an initial matter,

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13. The injunctive relief ordered by the district court in its February 21, 1990 order reads as follows:

> AND NOW, this 21st day of February, 1990, it is ORDERED:
>
> That, pending final revision of its Medicaid plan in conformity with this court's Memorandum and Order of January 24, 1990, the defendants shall, with respect to all of plaintiff's bills paid on or after January 25, 1990, utilize a payment rate of $3,643.09.
>
> IT IS FURTHER ORDERED that if it is later finally determined, either in this litigation or in the implementation of an acceptable revised medical assistance plan, that the amounts received by plaintiff pursuant to this Order are excessive, plaintiff shall promptly refund the excess, either by payment or by credit against future entitlement.

(App. 31).

14. The order which the district court entered in each of the Hospitals' pending cases on March 1, 1990 reads as follows:

> AND NOW this 1st day of March, 1990, upon consideration of the various pending applications for

DPW claims that the district court's orders providing interim injunctive relief are invalid because the district court erred in its liability determinations, which, as to Temple, were expressed in the district court's January 24, 1990 opinion, *Temple*, 729 F. Supp. 1093, and, as to the Hospitals, were expressed in the district court's March 1, 1990 orders. *See supra* note 14. We have earlier discussed the district court's merits/liability holding in *Temple*, and we are satisfied that the district court did not err in its analysis or in its holding that DPW did not meet the "findings" requirements of 42 U.S.C.A. § 1396a. *See supra* § III. DPW, as noted above, however, also challenges that holding as it applies to the Hospitals.

> interim relief, and for the reasons stated in this court's rulings on interim relief in the case of *Temple University v. John F. White, Jr.*, C.A. 88-6646 . . . (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:
>
> 1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.
>
> 2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

Albert Einstein Medical Center v. White, 732 F. Supp. 1329 (E.D. Pa. 1990). *See also Frankford Hosp. v. White*, unpublished order, No. 88-8927 (E.D. Pa. March 1, 1990), *reproduced in*, (Supp. App. 30a); *Hahnemann University Hosp. v. White*, unpublished order, No. 88-9132 (E.D. Pa., March 1, 1990), *reproduced in*, (Supp. App. 34a); *Hosp. Ass'n of Pennsylvania v. White*, unpublished order, No. 88-9848 (E.D. Pa. March 1, 1990), *reproduced in*, (Supp. App. 38a).

Because the district court subsumed in its March 1 order the merits holding which it had reached in *Temple*, DPW is correct when it argues that the Hospitals have received the benefit of the Temple merits determination without having been parties to the Temple proceeding or the Temple trial. DPW is not correct, however, in its assertion that the reasons given in the district court's January 24, 1990 merits opinion, as they pertain to Temple, do not extend to the Hospitals.

In this connection, the Hospitals call our attention to the doctrine of collateral estoppel. We have noted that this doctrine may be invoked where:

> (1) The issue decided in the prior adjudication was identical with the one presented in the later action;
>
> (2) There was a final judgment on the merits;
>
> (3) The party against whom the plea is asserted was a party or in privity with a party to the prior adjudication; and
>
> (4) The party against whom it is asserted has had a full and fair opportunity to litigate the issue in question in the prior action.

Gregory v. Chehi, 843 F.2d 111, 121 (3d Cir. 1988) (citations omitted). *See also Parklane Hosiery v. Shore*, 439 U.S. 322, 324, 326-33 (1979) (recognizing legitimacy of nonmutual offensive collateral estoppel as applied to give preclusive effect to previous federal court judgment).[15] DPW

15. DPW has not argued that the doctrine of collateral estoppel is inapplicable in this case. Indeed, no argument refuting the Hospitals' theory appears in DPW's briefs.

does not dispute that the issues raised by the hospitals in their related cases were raised, actually litigated, and decided against DPW in the *Temple* case. Neither does DPW dispute that it had a full and fair opportunity to litigate those issues nor that the decision rendered on those issues in *Temple* constituted a valid and final judgment on the *Temple* merits. Nor can it be argued that the determination of each of the issues contested in *Temple* was not essential to the district court's judgment. Because each of the elements required for the application of collateral estoppel or issue preclusion was satisfied, and because the invalidation of Pennsylvania's MAP necessarily affected the hospitals in Pennsylvania, we are persuaded that DPW's challenge to the March 1 orders as they pertain to the district court's liability determination voiding Pennsylvania's MAP, is meritless.[16]

We recognize, of course, that the March 1 orders which were entered to give relief to the Hospitals did not attempt to categorize each of the Hospitals by group or classification. Indeed, in these orders, the district court expressly disclaimed any such analysis when it granted relief "for the reasons

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16. While the district court did not explicitly base its order on the doctrine of collateral estoppel, it implied as much by basing its interim award on "the reasons stated in this court's rulings on interim relief in [*Temple*] (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features). . . ." *See supra* note 14. We review a district court's application of the doctrine of collateral estoppel only for abuse of discretion. *McLendon v. Continental Can*, 908 F.2d 1171, 1177 (3d Cir. 1990). In the context of the district court's rulings which we have reviewed and sustained and the district court's analyses, the district court did not abuse its discretion.

stated in this court's rulings on interim relief in the case of *Temple University v. John F. White, Jr.*, C.A. 88-6646 . . . (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features. . . .)." *See supra* note 14. Rather, the thrust of the March 1 orders was to reduce the budgetary adjustment from the arbitrary across-the-board 14% assessed by DPW, to a percentage not to exceed 2.4%. This ruling, based on collateral estoppel, *see supra* note 16, followed from the district court's analysis in *Temple* of the budget neutrality adjustment. *Temple*, 729 F. Supp. at 1098-99; *Temple*, 732 F. Supp. at 1328.

Having concluded that DPW had not complied with the federal statute and regulations governing its participation in the Medicaid Program and that the district court's orders to that effect extended not only to Temple but to the Hospitals, as well, we are satisfied that Temple and the Hospitals properly prevailed on the merits of their challenges to DPW's MAP, and, therefore, that they have met the threshold requirement for an award of injunctive relief against DPW. We turn, therefore, to DPW's remaining challenge to the "interim" injunctive relief which the district court ordered to remedy DPW's violation of Title XIX.

B

The district court styled the remedy in its February 21 and March 1 orders as "interim relief," despite the fact that they followed a final determination of liability, i.e., a holding that DPW had violated Title XIX, and despite the fact that the relief ordered partakes of all the characteristics

of a permanent injunction.[17] The parties, DPW on the one hand, and Temple and the Hospitals on the other, have argued that the character of the district court's February 21 and March 1 orders is significant because a difference exists in the standards by which a preliminary injunction and a permanent injunction are tested.

DPW claims that the orders at issue are preliminary injunctions and, as such, that irreparable injury had to be shown in order for the district court to enter its decrees. Moreover, DPW contends that, because no irreparable harm was found by the district court, its decrees cannot be sustained. *See Bill Blass Ltd. v. Saz Corp.*, 751 F.2d 152, 154 (3d Cir. 1984). Temple and the Hospitals counter this argument by claiming that the district court's orders constituted permanent injunctions and that as such irreparable harm need not be demonstrated. *See Ciba-Geigy v. Bolar Pharmaceutical*, 747 F.2d 844 (3d Cir. 1984). *But see Natural Resources Defense Council v. Texaco*, 906 F.2d 934, 941 (3d Cir. 1990).

While we have no difficulty in identifying the injunctive relief at issue here as permanent in nature, *see supra* note 17, we are, however, aware that different views have been expressed from time to time as to the need for establishing irreparable harm as a predicate to the entry of a permanent

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17. While we have acknowledged that the district court itself referred to the injunctive relief which it ordered as "interim," we read and understand the district court's orders as being "interim" only to the extent that the district court ordered a new MAP to be promulgated, and that the injunctive relief ordered was to continue in force until the new MAP became effective. We do not regard the characterization of "interim" relief as being synonymous with preliminary injunctive relief in the context in which this case has developed.

injunction.[18] Even if we could resolve an apparent conflict as to whether a permanent injunction requires the showing of irreparable injury, *compare*

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18. *Compare, e.g., Rondeau v. Mosinee Paper Corp.*, 422 U.S. 49 (1975) (although plaintiff prevailed on merits as to violation of Williams Act, absence of traditional showing of irreparable harm rendered permanent injunction unavailable); *Natural Resources Defense Council*, 906 F.2d at 941 ("[A] district court may issue a permanent injunction . . . *only* after a showing both of *irreparable injury* and inadequacy of legal remedies, and a balancing of competing claims of injury and the public interest.") (emphasis added) *with, e.g., Roe v. Operation Rescue*, 919 F.2d 857, 867 n.8 (3d Cir. 1990) (enumerating requirements for permanent injunctive relief, and not including irreparable harm among those requirements); *Ciba-Geigy*, 747 F.2d at 850 (where district court has correctly found that plaintiff has succeeded on the merits, court of appeals "must uphold the permanent injunction in its entirety so long as the balance of equities favors injunctive relief"); 11 Wright & Miller, Federal Practice and Procedure § 2944, at 399-401 & n.41 (1973 & West Supp. 1991) ("[I]rreparable injury is not an independent requirement for obtaining a permanent injunction; it is only one basis for showing the inadequacy of the legal remedy.").

See also Lewis v. S.S. Baune, 534 F.2d 1115, 1123-24 (5th Cir. 1976) ("In not all cases where petitioner fails to show irreparable injury will he still be denied a *permanent* injunction.") (emphasis in original); *K-Mart Corp. v. Oriental Plaza*, 875 F.2d 907, 914-15 (1st Cir. 1989) (for both preliminary and permanent injunction, requirements include a showing of irreparable harm, but "[t]he necessary concomitant of irreparable harm is the inadequacy of traditional legal remedies. . . . [I]f money damages will fully alleviate harm, then the harm cannot be said to be irreparable."); *New York State National Organization for Women v. Terry*, 886 F.2d 1339, 1362 (2d Cir. 1989) ("Generally, to obtain a permanent injunction a party must show the absence of an adequate remedy at law and irreparable harm if the relief is not granted.") (citing *Rondeau*, 422 U.S. at 57), *cert. denied*, 110 S. Ct. 2206 (1990).

Roe, 919 F.2d at 867 n.8 *with Natural Resources Defense Council*, 906 F.2d at 941, and obviously we cannot,[19] we, nevertheless, can proceed with our analysis because irreparable harm is reflected throughout the present record. Our disinclination to enter this thicket is prompted most importantly by the fact that, regardless of any distinction between the requirements for preliminary injunctions and permanent injunctions, and regardless of differing requirements found in our permanent injunction cases as to irreparable injury, the record here amply demonstrates the presence of irreparable harm.

C

The order entered by the district court on January 24, 1990, 729 F. Supp. at 1101, upon which all subsequent orders were based, was an injunctive order directing DPW to revise its MAP so that it would comply with all federal requirements. That order, consistent with the district court's opinion of that date, voided the MAP under which DPW had theretofore been operating. 729 F. Supp. 1093. Hence, as of

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19. Our Internal Operating Procedures provide that:

> It is the tradition of this court that the holding of a panel in a reported opinion is binding on subsequent panels. Thus, no subsequent panel overrules the holding in a published opinion of a previous panel. Court in banc consideration is required to do so.

Third Circuit I.O.P. 9.1. *See also* I.O.P. Intro. § A(2) (I.O.P.'s are designed to "insure decisional stability and avoid intra-circuit conflict of decisions by . . . [providing] that a holding of a published opinion of the court may not be overruled without the approval of a majority of the in banc court[.]").

January 24, 1990, no MAP was in place which could provide for any payments, regardless of amount, to Temple or to the Hospitals.[20]

While under other circumstances DPW's argument that "none of the Hospitals had established that they would close their doors without interim relief,"[21] might be persuasive, that argument fails here where Pennsylvania's MAP has been invalidated. Without an approved State plan, there can be no approved rates and, therefore, no payments available to be made by DPW to the hospitals. *See supra* note 20 (citing 42 C.F.R. § 447.253(g)). This consideration undoubtedly prompted the district court to find, in its February 21, 1990 opinion, that "it is appropriate to grant interim relief to mitigate irreparable loss which the plaintiff would otherwise suffer, pending final action on a revised plan." 732 F. Supp. at 1328.

Thus, whether or not irreparable injury is a requirement for a permanent injunction, the stark fact is that, in the present proceedings, irreparable injury and harm to the hospitals was threatened and became implicit the moment that the district court invalidated Pennsylvania's 1988-1989 MAP. At that point, as we have noted, no further authority existed for payments to the hospitals, thereby depriving Temple and the Hospitals, to the

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20. The federal regulations governing state payments include the following section:

> (g) *Rates paid.* The Medicaid agency *must pay* for inpatient hospital and long term care services using rates determined *in accordance with methods and standards specified in an approved State plan.*

42 C.F.R. § 447.253(g) (emphasis added).

21. Supplemental Brief of DPW, at 20.

extent that the *Temple* holding applies to them, of Pennsylvania's participation in its funding.

Indeed, the district court, in its February 21, 1990 opinion had observed that 44% of the Medicaid costs were the responsibility of Pennsylvania, with the remaining 56% the responsibility of the federal government. *Temple*, 732 F. Supp. at 1327-28. While we know of no case where the invalidation of a state plan resulted in a complete cessation of payments to the affected hospitals, the thrust of the Medicaid statute, 42 U.S.C.A. § 1396 *et seq.*, would indicate that, absent compliance by a participating state, the inevitable consequence might well be a collapse of such funding. In such circumstances, where Medicaid funding is endangered, we would be hard-pressed not to sustain the finding of the district court that Temple and the Hospitals would suffer irreparable harm, if such a showing were indeed required for the issuance of a permanent injunction.

The other elements to be considered in decreeing a permanent injunction consist of a showing of success on the merits, the inadequacy of legal remedies, and a balancing of competing claims of injury and the public interest. *See, e.g., Natural Resources Defense Council*, 906 F.2d at 938, 941; *Roe* 919 F.2d at 867 n.8. Each of these factors is satisfied in this case. As to the merits, Temple and the Hospitals, as we have discussed, had prevailed on the merits of their claim that DPW had not complied with applicable federal laws and regulations and had established payment rates through methods that did not meet federal standards. As to the inadequacy of legal remedies, the Eleventh Amendment bar to an award of

retroactive damages against the Commonwealth, *see Temple*, 732 F. Supp. at 1327-28, clearly establishes that any legal remedy is unavailable and that the only relief available is equitable in nature. *See National Resources Defense Counsel*, 906 F.2d at 938, 941; *Roe*, 919 F.2d at 867 n.8.

With respect to balancing the equities, even a cursory reading of the district court's January 24, 1990 opinion demonstrates the painstaking care that the district court took in weighing the competing claims and in balancing the interests of Temple, the Hospitals, and the medically needy on the one hand, against the interests of the Commonwealth, on the other. *See Temple*, 729 F. Supp. 1093. Thus, we are satisfied that all the criteria necessary for the injunction decreed by the district court were present.

D

The district court's injunctive remedy consisted of two parts. The first and most fundamental part was the requirement imposed by the district court that DPW promulgate a new MAP. The district court's injunctive order in this respect, directed that DPW "take all necessary steps to bring the Pennsylvania Medical Assistance Plan into compliance with federal requirements consistent with [the district court's January 24, 1990] Memorandum." 729 F. Supp. at 1101. The second part of the district court's injunction required interim payments to be made by DPW to Temple and the Hospitals (to the extent that the Temple February 21, 1990 order pertains to the Hospitals), *see supra* note 14, until the new MAP takes effect. While DPW contends that its present MAP should not have been invalidated, i.e., that DPW should

have prevailed on the merits, it also attacks the interim relief which the district court provided in its orders of February 21, 1990 and March 1, 1990.

We are satisfied that the district court had inherent discretion to fashion a remedy in aid of, and in implementation of, its own judgment which required DPW to formulate a new MAP. Having determined that a new MAP was required which would provide payment rates to Temple and to the Hospitals in accordance with federal prescriptions, it is evident to us, as it must have been to the district court that, until such time as DPW complied with the January 24, 1990 order and presented a new MAP, provisional payments had to continue so that the medically needy could be served and Temple and the Hospitals could remain effective as providers of medical services. The district court's task, in a situation where a violation of this nature is found, is to correct the condition by balancing the individual and collective interests. *See Swann v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 1 (1971) (in a constitutional context). While the scope of a district court's equitable powers to effect a remedy is broad, the relief which a district court may grant can be no broader than that necessary to correct the violation. Indeed, a federal court is required to tailor the scope of its remedy in order to fit the nature of the violation which it has found. *Resident Advisory Board v. Rizzo*, 564 F.2d 126 (3d Cir. 1977), *cert. denied*, 435 U.S. 908 (1978). As we said in *Resident Advisory Board*, albeit in a constitutional context, the federal equitable remedy must cure the constitutional defect, but the dosage must not exceed that necessary to effect the cure. 564 F.2d at 145.

In this case, the district court, recognizing that any acceptable Medicaid plan must be devised by DPW, nevertheless undertook to establish an interim payment level "based upon eliminating only the most obvious and clearcut inadequacies of the present plan." 732 F. Supp. at 1328. It is clear to us that the entire focus of the district court's endeavors, once it had concluded that Pennsylvania's 1988-1989 payment rates were invalid, was to require a new payment rate plan to be formulated by DPW as expeditiously as possible and to protect that judgment by providing for interim payments which would sustain the system until such time as the new MAP was drawn and approved. Having concluded that all the criteria necessary for the injunctive relief ordered by the district court were present, both with respect to the injunctive decree requiring revision of the MAP and with respect to the injunctive decrees providing for interim relief, (particularly because it was evident that some payments had to be ordered to maintain the hospital system and to service the medically needy), we can find no fault with the action taken by the district court or with the orders entered by the district court to effectuate the objectives inherent in the Medicaid Program.

V

A

On August 14, 1990, the district court, among other things, ordered that DPW make four payments of $500,000 each to Sacred Heart Hospital as an advance against future medical assistance payments. A threshold issue of appellate jurisdiction is presented by this appeal.

We are bound to determine our own jurisdiction, even if the parties do not raise this issue. *See Firestone v. Risjord*, 449 U.S. 368, 379 (1981). In this case, the parties did not call our attention to the jurisdictional problem, and indeed, when that issue was raised, both DPW and Sacred Heart argued that we should not dismiss the appeal for failure of jurisdiction.

The district court's August 14, 1990 order was made orally from the bench and was not reduced to writing, nor was it entered on the clerk's docket. At that stage, therefore, we could not obtain appellate jurisdiction to review an unrecorded order. *Banker's Trust v. Mallis*, 435 U.S. 381 (1978), relied upon by the parties, is not to the contrary. In *Banker's Trust*, the Court recognized that no order had been written which satisfied the separate document requirement of Fed. R. Civ. P. 58. The Court also recognized, however, that the parties could waive that requirement, and, in so doing, affirmed its appellate jurisdiction over the case. However, the Court took pains to note that there had been an entry of the order in the district court clerk's docket. The Court stated:

> Here, the district court clearly evidenced its intent that the opinion and order from which an appeal was taken would represent the final decision in the case. *A judgment of dismissal was recorded in the clerk's docket.*

435 U.S. at 387 (emphasis added). Here, to the contrary, no entry of the August 14, 1990 order appears in the clerk's docket. In the absence of both a written order satisfying the "separate document" requirement and in the absence of an entry in the clerk's docket, the notice of appeal,

which was filed on September 4, 1990, could not vest jurisdiction in this court despite the parties' apparent waiver of the separate document requirement.[22]

However, an event that occurred subsequent to the August 14 order suffices to satisfy us that we have the right to review DPW's appeal. On August 23, 1990, the district court, in response to a motion filed by Sacred Heart, directed that the order of August 14, 1990, which had been sealed and which is the order under appeal here, be unsealed. Prior to that time, Sacred Heart had succeeded in having its motions to seal the pleadings and record granted. For reasons which do not appear of record, Sacred Heart moved to amend the district court's order dated August 14, 1990 by having the August 14th order unsealed. The order of the district court reads as follows:

> AND NOW, this 23rd day of August 1990, upon consideration of Plaintiff, Sacred Heart Medical Center's Motion to Amend this Court's Order dated August 14, 1990 sealing the pleadings and record herein, it is hereby ORDERED AND DECREED that:

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22. In *Banker's Trust*, the Supreme Court explained the purposes of entering a decision on the docket:

> Because Rule 58 provides that a "judgment is effective only . . . when entered as provided in Rule 79(a)," it is arguable that a decision must be entered on the civil docket before it may constitute a "final decision" for purposes of § 1291. Unlike the separate-document requirement, . . . the keeping of a civil docket pursuant to Rule 79 fulfills a public recordkeeping function over and above the giving of notice to the losing party that a final decision has been entered against it.

435 U.S. at 384 n.4.

> Said Order is amended to permit the unsealing of the Order entered by this Court at the end of the Hearing August 14, 1990. A copy of that Order is attached hereto as Exhibit A.

(SH App. 158).

It is significant to us that a copy of the August 14, 1990 order which the court ordered to be "unsealed" was attached to the unsealing order of August 23, 1990 as Exhibit A. The August 23 order *is* entered on the clerk's docket, and although the August 14 order, to which the unsealing order refers, does not appear either on the clerk's docket or in written form in the record, for purposes of appellate jurisdiction we are satisfied that the entry on the clerk's docket of the August 23 order, with its Exhibit, is sufficient to permit us to review DPW's appeal. We turn, then, to DPW's argument on the merits.

B

DPW argues first that because the district court erred in invalidating DPW's MAP and in finding that DPW was in violation of Title XIX, as it did in its *Temple* holding, that Sacred Heart's claim, which is premised on that holding, must also fail. The short answer to this argument is found in our earlier analysis of the district court's *Temple* holding, which was predicated on a failure of DPW to make its findings required by 42 U.S.C.A. § 1396 *et seq.*, and our discussion of collateral estoppel which extended the district court's *Temple* holding to the Hospitals. *See supra* §§ III and IV. We are satisfied that the decision of the district court as to liability must be sustained, and, in sustaining the orders of the district court in this respect, we reject DPW's first argument.

DPW also argues that the district court's decision to grant interim relief for Sacred Heart is against the weight of the evidence, inasmuch as Sacred Heart had a history of financial problems which DPW claims was responsible for Sacred Heart's financial plight, rather than the inadequacy of DPW's MAP. In addition, DPW argues that the district court erred when it directed that DPW make advance payments to Sacred Heart without requiring that a bond be posted pursuant to Fed. R. Civ. P. 65(c). We also briefly address the issue of mootness which was the subject of our inquiry after learning of the Settlement agreements executed by the parties. *See infra* note 5. We turn to these arguments.

(1)

On August 14, 1990, the district court judge enjoined DPW to pay $2 million in advance payments to Sacred Heart Hospital by directing:

> I, therefore, will direct that the defendants pay to the Sacred Heart Hospital beginning within 10 days from today the following sums:
>
> The sum of $500,000.00, the first payment to be made within 10 days from today and a like payment of $500,000.00 each of the next three months for a total of four months of payments or a total of $2 million spread out over the four-month period with the understanding:
>
> No. 1, that this is an advance against future medical assistance payments and the reimbursement of this $2 million in the form of credits against future medical assistance payments will begin January 18th, 1991 or 30 days after submission of an acceptable MAP plan; and

> It is further understood that upon presentation of a revised MAP plan, whenever that occurs, the defendants will be at liberty to seek a modification of this order with respect to any advances which have not yet occurred if they can establish that under the appropriate MAP plan the adjustments will not – that these additional payments will not be justified.

(SH App. 155).

The district court ordered this relief in light of underpayment of Medicaid rates to Sacred Heart in past years; DPW's failure to promulgate a new MAP providing for a higher payment rate; and the need "to make some appropriate adjustment for the interim period . . . which will prevent the insolvence [sic] or a bankruptcy of Sacred Heart Medical Center at least in that interim period. . . ." (SH App. 154).

As we have noted in an earlier part of this opinion, *see supra* note 5, sometime subsequent to the filing of the appeals that we consider today, DPW entered into a Stipulation of Settlement with Temple and the Hospitals and into a special agreement with Sacred Heart. The parties to these agreements were satisfied that entering into them did not moot out these appeals or proceedings underlying the appeals, *see, e.g.*, Stipulation of Settlement, p. 33, paragraph 6.5, and indeed, after supplementing the record on these appeals with the settlement documents, and after additional briefing, we, too, were satisfied that the appeals in gross have not been mooted.

Our determination that the appeals were still viable did not reflect the fact, however, that some aspects of the appeals may have been mooted by the action of the parties. In our view, DPW's

payments totalling $2 million, payments which had been completed, may very well have mooted DPW's argument that the district court erred in directing those payments, particularly because we understand that the agreement which DPW made with Sacred Heart would now govern the relationship of the parties with respect to those payments.

(II)

However, we do not rest our decision on the ground of mootness, for we are satisfied that the standard by which a district court's decree of injunction is tested – whether the district court properly exercised its discretion – was not abused in this case. First, as we have observed, Sacred Heart has succeeded on the merits of its claim. Second, whether or not irreparable harm is deemed a factor in the injunction analysis, as DPW claims that it is, irreparable harm has been more than demonstrated by the finding made by the district court that without emergency relief, Sacred Heart would become insolvent. (SH App. 154).

The district court further noted that even DPW did "not dispute the fact that, if a stay [of the emergency relief award] is granted, financial collapse of the Sacred Heart Medical Center is virtually certain to occur." (SH Supp. App. 5). While DPW did not dispute the fact that Sacred Heart was in severe financial straits, it did dispute the district court's finding that Sacred Heart's potential financial collapse/insolvency was related to DPW's MAP. The district court, however, found otherwise, and we cannot hold that finding to be clearly erroneous in light of the district court's determination that Sacred Heart's financial "inefficiencies" are insignificant. (SH App. 155).

A fair reading of the district court's October 18, 1990 memorandum reveals that the district court weighed the risks to DPW,[23] and balanced the interests of Sacred Heart, DPW, and the public in requiring the advance payments to be made to Sacred Heart. From any standpoint, and particularly considering the fact that no legal remedy was either adequate or available, we conclude that the district court's injunctive order was well within its broad discretionary power. Hence, even if by completing payments of the $2 million advance and the execution of the settlement agreements, the issues presented by the DPW were not moot, the injunction itself, as entered by the district court, was not an abuse of discretion.

(iii)

DPW argues that the district court erred in awarding emergency relief to Sacred Heart without requiring it to post a bond pursuant to Fed. R. Civ. P. 65(c).[24] While Rule 65(c) does state that a plaintiff shall post a security bond before a district court may grant a preliminary injunction, we have

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23. "The risk that the defendants will suffer any significant prejudice as a result of these interim payments is, for the reasons mentioned above, very slight or non-existent." (SH Supp. App. 6).

24. Fed. R. Civ. P. 65(c) provides in relevant part as follows:

> (c) Security. No restraining order or preliminary injunction shall issue except upon the giving of security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained.

acknowledged, on several occasions, that there may be instances in which a strict reading of Rule 65(c) would be inappropriate.[25] While we have not previously addressed a situation where the bond requirement of Rule 65(c) could properly have been waived, we note that several other circuits have held that a district court may dispense with that requirement under certain narrowly drawn circumstances.[26]

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25. *See Hoxworth v. Blinder, Robinson & Co. Inc.*, 903 F.2d 186, 211 n.32 (3d Cir. 1990) (noting that if an exception to the bond requirement is drawn, it "should be drawn narrowly"); *Instant Air Freight v. C.F. Air Freight*, 882 F.2d 797, 803 n.8 (3d Cir. 1989) (recognizing that "[o]ther courts of appeal have held that certain non-commercial and public interest cases may require dispensing with the bond"); *System Operations v. Scientific Games Dev. Corp.*, 555 F.2d 1131, 1146 (3d Cir. 1977) (adding that there was no need to "decide whether a court may dispense with the posting of a bond in a case where the injunction raises no risk of monetary harm to the defendant"). *Cf. Frank's GMC Truck Center v. G.M.C.*, 847 F.2d 100, 103 (3d Cir. 1988) (noting that "[w]hile there are exceptions, the instances in which a bond may not be required are so rare that the requirement is almost mandatory").

26. *See, e.g., Crowley v. Local No. 82, Furniture & Piano*, 679 F.2d 978 (1st Cir. 1982), *rev'd on other grounds*, 467 U.S. 526 (1984) (upholding denial of bond where Union members would have had financial difficulty posting it, and where defendants faced low burden from absence of security); *International Controls v. Vesco*, 490 F.2d 1334, 1356 (2d Cir. 1974), *cert. denied*, 417 U.S. 932 (1974) (noting that "the district court may dispense with security where there has been no proof of likelihood of harm to the party enjoined") (citations omitted); *Corrigan Dispatch Co. v. Casa Guzman, S.A.*, 569 F.2d 300 (5th Cir. 1978) (trial court may elect not to require security bond where entire purchase price of disputed sale was paid into registry of court); *Urbain v. Knapp Brothers Mfg.*, 217 F.2d 810 (6th Cir. 1954) (no bond required where defendant would not appear to face material damage);

In particular, the First Circuit has articulated an appropriate analysis that a district court should employ in deciding whether or not to require a bond. *Crowley v. Local No. 82, Furniture & Piano*, 679 F.2d 978 (1st Cir. 1982), *rev'd on other grounds*, 467 U.S. 526 (1984). "First, at least in noncommercial cases, the court should consider the possible loss to the enjoined party together with the hardship that a bond requirement would impose on the applicant." *Id.* at 1000. Here, Sacred Heart was on the brink of financial ruin and would have become insolvent absent the relief which the district court ordered. Furthermore, the district court found that virtually no risk existed for DPW in advancing funds to Sacred Heart, because of the probability that the hospital would be entitled to as much or more monies pursuant to DPW's new MAP. The emergency relief itself ensured Sacred Heart's financial solvency, and DPW could recoup any overpayment of funds by withholding on future payments to Sacred Heart. The equities of potential hardships to the parties, therefore, weighed in favor of waiving the bond requirement.

The First Circuit also noted the special nature of suits to enforce important federal rights or

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Wayne Chemical v. Columbus Agency Serv. Corp., 567 F.2d 692 (7th Cir. 1977) (no bond required from indigent plaintiff); *People Ex Rel. v. Van De Kamp v. Tahoe Regional Plan*, 766 F.2d 1319 (9th Cir. 1985) (holding non-profit environmental group would be denied access to judicial review if court did not properly exercise its discretion to dispense with security requirement); *Continental Oil v. Frontier Refinery*, 338 F.2d 780 (10th Cir. 1964) (no bond required where likelihood of harm to defendant is absent).

"'public interests,'" arising "out of comprehensive federal health and welfare statutes." *Crowley*, 679 F.2d at 1000. A district court should consider the impact that a bond requirement would have on enforcement of such a right, in order to prevent undue restriction of it. *Id.* In this case, Sacred Heart has sued to enforce the rights granted to it under the federal Medicaid statute, and in so doing has pursued a course of litigation clearly in the public interest, i.e., it seeks to preserve its role as a community hospital serving a disproportionate share of low income patients.[27] In light of the district court's discussion, it appears improbable that, had the district court required Sacred Heart to post a bond, the hospital would have been able to do so. Moreover, had Sacred Heart suffered a financial collapse, it would have been in no position to pursue its claim for increased Medicaid payments, or even to serve its Medicaid patients. The district court's waiver of the bond requirement under these circumstances, then, falls within the

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27. Public policy under [federal law governing state modification of Medicaid programs] mandates that parties in fact adversely affected by improper administration of programs pursuant thereto be strongly encouraged to correct such errors. . . . [T]he allocation of risk for not complying with federal law in a comprehensive program to promote national health . . . properly rests upon the defendant governmental bodies whose administration of the program is at issue.

Bass v. Richardson, 338 F. Supp. 478, 491 (S.D.N.Y. 1971) (waiving the Rule 65(c) bond requirement).

exception to Rule 65 formulated by the First Circuit - an exception which we adopt today.[28]

VI

We have sustained the district court's invalidation of Pennsylvania's MAP, providing for 1988-1989 payment rates, and the remedies ordered by the district court, including the district court's requirement that a new MAP be devised which complies with all requirements of Title XIX. We have also upheld the interim remedies fashioned by the district court which will remain in effect until DPW complies with the district court's order of January 24, 1990. With respect to Sacred Heart, we have sustained the district court's order for advance payments which were to be made without bond. Accordingly, the district court's orders of January 24, 1990 (Temple); February 21, 1990 (Temple); March 1, 1990 (Hospitals); August 14, 1990 (Sacred Heart); and August 23, 1990 (Sacred Heart) will be affirmed in all respects.

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28. Because we have upheld the district court's injunction requiring the payment of advances to Sacred Heart, even if we had not adopted an exception to Rule 65 and had, therefore, concluded that the district court had erred in not requiring a bond, DPW would only have been entitled to a remand for reconsideration of that issue. *See Crowley*, 679 F.2d at 1000. The district court could have, at that point, required the posting of a nominal bond, and the case would have proceeded apace. *See Frank's GMC*, 847 F.2d at 103 (noting that "the amount of the bond is left to the discretion of the court").

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

(A.O. U.S. Courts. G.M.C. Printing. Phila., Pa. 215-568-4264)

TEMPLE UNIVERSITY--OF THE
COMMONWEALTH SYSTEM
OF HIGHER EDUCATION

v.

John F. WHITE, Jr.; Eileen M. Schoen; David S. Feinberg; David D. Ulsh; and G. June Hoch.

Civ. A. 88-6646

United States District Court,
E.D. Pennsylvania.

Jan. 24, 1990.

Matthew M. Strickler of Ballard, Spahr, Andrews & Ingersol, Philadelphia, Pa., for plaintiff.

Kate L. Mershimer, Deputy Atty. Gen., Harrisburg, Pa., for defendants.

MEMORANDUM AND ORDER

FULLAM, Chief Judge.

Plaintiff is a Pennsylvania non-profit corporation which operates Temple University Hospital. It has brought this action against various officials of the Commonwealth of

Pennsylvania, invoking 42 U.S.C. § 1983, asserting that the defendants have deprived Temple of rights secured by Title XIX of the Social Security Act, 42 U.S.C. § 1396a et seq. in their administration of the payment system for in-patient hospital care under the Pennsylvania Medical Assistance Program.

At issue are such matters as whether defendants are meeting the statutory requirement that the State's Medical Assistance program must provide payments to hospitals that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals; whether Pennsylvania's Medical Assistance program is based upon the statutorily required findings and certification; and whether the Program adequately takes into account the special problems of hospitals which,

like Temple, serve a disproportionate number of low-income patients. Before addressing the merits, however, it is necessary to refer briefly to defendants' threshold argument that plaintiff cannot maintain this action under 42 U.S.C. 1983 for violation of alleged federal statutory rights, because Title XIX gives rise to no rights which can be asserted by hospitals. This precise argument has been persuasively rejected by the Third Circuit Court of Appeals in West Virginia Univ. Hospitals, Inc. v. Casey, et al., 885 F.2d 11 (3d Cir., 1989), and I am bound by that decision.[1]

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[1] I recognize that the United States Supreme Court has recently granted review of a Fourth Circuit decision to the same effect as West Virginia Hospital, in Virginia Hospital Ass'n v. Baliles, 868 F.2d 653 (4th Cir.1989), cert. granted, ___ U.S.____, 110 S.Ct. 49, 107 L.Ed.2d 18, (1989). In addition to these Third and Fourth Circuit decisions, I

CONTINUED ON NEXT PAGE

I. FACTUAL BACKGROUND

For several years, hospitals received reimbursement for costs actually expended in the care of Medicaid patients, on the basis of cost figures submitted to and audited by the appropriate state authorities. In the belief that this reimbursement system provided inadequate incentives to hospitals to operate efficiently, and in order to cope with rapidly escalating Medicaid hospital costs, Congress, as part of the '81 Omnibus Reconciliation Act (OBRA), P.L. 97-35, established a new standard of hospital reimbursement.

FOOTNOTE 1 CONTINUED
note that virtually every court of appeals which has squarely considered the question has found that hospitals can challenge state Medicaid plans under § 1983. The cases are listed in the most recent decision of the Tenth Circuit on this subject, Amisub (PSL), Inc. v. State of Colorado, Dept. of Social Services, 879 F.2d 789, 794 (10th Cir.1989).

Whereas, previously, hospitals were to be reimbursed "the reasonable cost" of rendering in-patient services; the OBRA replaced that standard with the current standard requiring payments to hospitals at rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities". 42 U.S.C.A. § 1396a(a)(13)(A) (West Supp.1989). The statute and accompanying regulations afford considerable leeway to the States to determine the precise methods by which payments to hospitals will be calculated in order to meet the statutory standard, but require States to make findings and give assurances that the plan adopted does in fact comply with federal requirements.

Pennsylvania's Medical Assistance Program established a complex system for classifying hospitals into groups thought

to face similar external constraints affecting their costs; classifying medical procedures performed in hospitals into groups thought to involve essentially similar costs; calculating the average cost per procedure, experienced by hospitals in each group; and, after various adjustments including a so-called "budget neutrality factor" and an upward adjustment for hospitals burdened disproportionately with indigent patients, resulting in a formula by which hospitals are paid prospectively, without regard to their actual expenditures. The changeover from the old system to the new system was phased in over a three-year period.

The Third Circuit Court of Appeals, in West Virginia Univ. Hospitals, supra, held that this precise medical assistance plan was invalid, for non-conformity with the requirements of Title XIX, insofar as

it affected out-of-state hospitals. That holding is not, of course, directly controlling in the present case, because we are dealing with in-state hospitals, and with a different reimbursement formula. But the thorough discussion and analysis of the statute, the regulations, and the legislative history provided by Judge Rosenn's opinion in that case makes it unnecessary to undertake a similar exposition here. It is sufficient to note that Judge Rosenn identifies three criteria which medical assistance plans must meet in order to conform to Title XIX: (1) the plan must take into account the situations of those hospitals which serve a disproportionate number of low-income patients; (2) the plan must be based upon a finding and certification that the rates are reasonable and adequate to meet the necessary costs of

an efficiently operated hospital; and (3) the plan be based upon a finding and certificate that the rates will assure Medicaid patients reasonable access to in-patient hospital care. Judge Rosenn refers to these as the "disproportionate share; requirement, the "reasonable and adequate" requirement, and the "reasonable access" requirement. As to the first and third, judicial review is plenary, but as to the "reasonable and adequate" standard, judicial review is limited to inquiring whether the state's determination is arbitrary and capricious (slip op. pp. 24, 25). Notwithstanding this deference to the state's determination of what constitutes a

reasonable and adequate rate of reimbursement, the process by which that determination was reached--the adequacy of its factual investigation and findings-must also conform to the statutory requirements.

Temple's Experience

Temple University Hospital serves a North Philadelphia community which is principally black, hispanic and indigent. The majority of Temple's patients are blacks and hispanics who live in poverty. Fifty-percent of Temple's patients have Medicaid insurance coverage; 20% are covered by Medicare; and 5% have no coverage.

Approximately 2,100 children are born at Temple Hospital each year. The neo-natal mortality rate in that community is more than twice the national average. Approximately 20% of the

mothers enter Temple Hospital without having had any prenatal care. Many are addicted to drugs; about 20% of the babies born at Temple Hospital show evidence that their mothers consumed cocaine during pregnancy. Six percent of the babies born at Temple suffer from low birth weight or other problems, including sexually transmitted diseases.

Nursing costs represent approximately 22% of Temple's total operating costs. Although Temple does not have the highest pay scale in the area, the rate of pay for nurses at Temple increased more than 37% between 1980 and 1988. Because of its pay scale, Temple has difficulty retaining nurses; its ratio of nurses to occupied beds is among the lowest of the teaching hospitals. Temple's professional liability insurance costs and similar

obligations beyond its control have increased dramatically in recent years. For example, its premium for Pennsylvania's Catastrophic Loss Fund increased approximately 400%. Utility costs have increased at a rate of approximately 20% to 12% per year; the cost of disposable supplies and pharmaceuticals has increased at the rate of approximately 9.5% each of the last several years.

On average, Philadelphia medical school hospitals employ 6.1 full-time employees per occupied bed; Temple's rate is 5.3. Temple's housekeepers are required to clean between 30% and 50% more square footage than the industry norm.

Temple's current occupancy rate is approximately 84% to 85%, an increase of 21% since 1984.

Under the Department of Public Welfare's ranking system, Temple is one of seven hospitals with the highest score; it has the least costs of these seven hospitals; its costs are below the weighted average cost of all hospitals classified in the same group under the Medical Assistance Program (Class 1).

Under the Pennsylvania Medical Assistance Program, Temple receives approximately 81% of its actual costs for medical assistance patients; during fiscal year 1988-89, Temple will lose approximately $7.8 million on in-patient care to medical assistance patients.

During each of the years since the inception of the prospective payment system, Temple's medical assistance payments have been inadequate to cover its medical assistance reimbursable costs. The shortfall between its costs

for medical assistance in-patient care and its reimbursement have been as follows:

FY '1985 - $2,504,617

FY '1986 - $2,525,899

FY '1987 - $5,086,863

FY '1988 - $6,218,785

FY '1989 - (estimated) $7,790,427

To some extent, Temple has been able to achieve cross- subsidization from other payors, but it will nevertheless experience a loss of $3,256,155 on in-patient care during the current fiscal year. Its loss for fiscal year 1989-90 is expected to rise to somewhere between $4.5 and $5.2 million on in-patient care.

Plaintiff presented a mass of evidence, which stands unrebutted, to the effect that it has cut costs in every conceivable way, and that, as a practical matter, no further "efficiency" or "economy" is possible.

Defendants' response, in essence, is that since the Medical Assistance Plan is designed to provide reasonable and adequate reimbursement of the costs which would necessarily be incurred by an efficient institution, the shortfall between Temple's costs and the reimbursement provided by the Plan is proof that Temple is not an efficient hospital. Although this seems, at first blush, to be a rabbit-in-the-hat type of argument, it is one which follows inevitably from the design of the Medical Assistance Plan established by the defendants, as will be discussed in the following section.

II. REASONABLE AND ADEQUATE COSTS INCURRED BY EFFICIENT AND ECONOMICAL HOSPITALS

[1] Opponents and proponents of the Pennsylvania Medical Assistance Plan

(MAP) agree on certain basic principles. What in-patient care should reasonably cost depends upon the nature of the care provided, and the circumstances of the provider. The first step in the analysis, therefore, is to identify and classify the diseases or conditions which require in-patient hospital care. Thus, Pennsylvania's MAP identifies some 477 categories of Diagnostic-Related Groups (DRGs). For each DRG, a flat fee is established, regardless of whether the patient actually received more or less than the standard treatment. In Pennsylvania, the relative value for each DRG is computed by:

(a) determining the total standardized cost for all approved claims in the data base (i.e., previous experience);

(b) determining the total number of medical assistance hospital cases in the data base;

(c) dividing the total standardized cost by the total number of cases to establish a statewide average cost per case for all cases;

(d) determining the total standardized costs and total number of cases for each DRG;

(e) dividing the total costs for each DRG by the corresponding number of cases for that DRG to establish an average cost per case for each DRG; and

(f) dividing the average cost per case for each DRG by the statewide average cost per case for all cases to establish the relative value for each DRG [Stipulation 38].

Thus, historical costs for similar kinds of hospital admissions are the starting point for calculating reimbursements under the plan.

The next step under the Plan was to classify hospitals into groups, in an effort to treat similarly situated institutions in similar fashion. The classification process involved ranking each institution on a series of 13 variables in 4 categories, teaching, medical assistance volume, environment and cost. The variables included such matters as number of full-time employed physicians/residents/interns per bed; number of full-time equivalent physicians, residents and interns; and number of residency programs (the teaching concept variables); medical assistance reimbursable in-patient costs, separately and in relation to total

in-patient costs; acute care in-patient medical assistance in-patient days, separately and in relation to total acute care in-patient days (medical assistance volume concept); percentage of persons below the poverty level in that county, median family income in that county, percentage of unemployment in that county (environmental characteristics); and medicare area wage index, total in-patient expenses adjusted for direct medical education and capital/total in-patient admissions; and total in-patient expenses adjusted for direct medical education and capital/total in-patient days (hospital costs concept). [Stipulation 41.] For each of these 13 variables, a hospital would recieve a numerical score which resulted in a separate ranking within each concept area.

On the basis of these numerical rankings, hospitals were placed in any one of eight groups. Three children's hospitals were placed in a separate group, and the remaining hospitals divided into seven groups. Group 1 hospitals have the highest cost-factors, group 7 the lowest. A separate group payment rate was established for each group.

The defendants pegged the group rate for each group at somewhat more than the costs incurred by the lowest-cost hospital within that group, but considerbly less than the costs incurred by the average hospital within that group. Presumably, this was done on the theory that similarly situated hospitals should be encouraged to emulate the example of the lower-cost hospitals within that group.

The defendants pegged the group rate for each group at somewhat more than the costs incurred by the lowest-cost hospital within that group, but considerably less than the costs incurred by the average hospital within that group. Presumably, this was done on the theory that similarly situated hospitals should be encouraged to emulate the example of the lower-cost hospitals within that group.

There are several problems with this approach, both theoretical and practical. Assuming that the hospitals are grouped appropriately, and that the hospitals within a particular group are indeed similarly situated, and assuming that the lowest-cost hospitals within that group are the most efficient, the incentive is double-edged: whereas some fairly low-cost institutions might be encouraged to reduce their costs still

further, those at the higher end of the spectrum within a particular group would do better to increase their costs and become less "efficient", in order to qualify for membership in the next-higher group. In short, grouping hospitals according to their actual cost experience (rather than in accordance with the similarity of their circumstances affecting costs), produces a result having little or nothing to do with whether the hospitals are being run efficiently and economically.

This difficulty is exacerbated by the fact that hospitals are assigned to groups, not because their scores on the ranking test were comparable, but simply in order to achieve seven groups of near-equal size. Thus, there is greater variation among the hospitals in group 1 (the scores in that group range from 913 to 724) than there is between the

highest-scoring hospital in group 3 (608) and the lowest- scoring hospital in group 7 (439).

Group 1 hospitals rank highest in teaching, medical assistance volume, environmental factors, and costs. But the hospitals assigned to that group are far from homogeneous. The group includes the six Philadelphia teaching hospitals (Temple, Penn, Jefferson, Medical College of Pennsylvania, Hahnemann, and Osteopathic); Germantown Hospital, a primary- care hospital in Philadelphia; and Springfield Hospital in Delaware County. Within that group, the ratio of full-time residents per bed varies from .688 (Medical College of Pennsylvania) to .124 (Springfield); the ratio of acute-care medical assistance costs to total costs varies from .361 (Temple) to .042 (Springfield).

In order to receive full medical assistance reimbursement, a hospital must rank relatively low within its group. It is simply impossible for a hospital such as Temple, which ranks high in the group, to receive payments equal to its costs. Plaintiff's statistical expert, Dr. Siskin, has convincingly demonstrated that whether a hospital will or will not receive full-cost reimbursement is, under the MAP, essentially unrelated to efficiency; it depends upon where it ranks, within that particular group, on the variables; the higher ranking within the group, the greater the likelihood, even certainty, of a shortfall. But the very purpose of rank- scoring on the variables was to identify the hospitals entitled to higher rates of reimbursement.

A further, major, difficulty with Pennsylvania's MAP is that, after

determining the group rate for each group, application of a "budget neutrality" factor results in an across-the-board 14% reduction. That is, hospitals within each group receive only about 86% of the costs incurred by the hospitals at the lower end in that group.

The defendants' attempts to justify this reduction are not entirely consistent with each other, or with the evidence. Initially, the concept of a budget-neutrality adjustment was introduced as a part of the transition to the system of prospective payment; it was designed to make sure that total payments under the prospective payment system would not exceed what they would have been for the same level of services, under the old system. Another justification advanced by the defendants is that, under the old system, there was

usually a shrinkage between the cost figures submitted by hospitals in claiming reimbursement and the final audited figures. Since the prospective payment formula was based in part upon the hospitals' (unaudited) costs, it was reasonable to suppose that there should be a similar shrinkage between the defendants' initial projections and the correct prospective payment estimate.

These theoretical justification do not hold water. The discrepancy between audited and unaudited cost figures under the old system seldom, if ever, exceeded 2%; and no attempt has been made to determine, in recent years, how the total cost under the new system compares with the costs which would have been incurred had the old system remained in effect. The defendants' own calculations at the time projected little or no difference.

Plaintiff's expert, Dr. Coelen, performed a study suggesting that the maximum budget neutrality adjustment should be only about 2.4%.

The evidence makes very clear that the "budget neutrality" adjustment, like other features of the MAP, is entirely budget-driven. It is simply a mechanism for keeping total medical assistance costs within the Welfare Department budget. Moreover, the across-the-board approach--applying the adjustment equally to all hospitals and all groups without regard to their relative level of efficiency or other pertinent circumstances--is utterly inconsistent with the notion of rewarding efficiency.

In short, Pennsylvania's reimbursement rates are simply arbitrary.

III.DISPROPORTIONATE SHARE ISSUES

[2] In order to comply with Title XIX, the MAP must use rates established according to standards "which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs ...". There is no dispute about the fact that Temple does serve a disproportionate number of such indigent patients. Pennsylvania's MAP provides for additional payments to such hospitals, ranging from a low of 0.5% to a high of 2.5%. Temple qualifies for the 2.5% add-on. Unfortunately, it is also undisputed that this represents only a small fraction of the total increase in costs attributable to Temple's status as a disproportionate-share hospital. As the defendants' own calculations demonstrate, full

recognition of Temple's status as a disproportionate-share hospital would result in an add-on of at least 16%. The parties disagree as to whether this is in conformity with Title XIX.

The statute permits states to calculate the required additional payments to disporportionate-share hospitals either by adopting the same formula used in the Medicare Program, or by adopting their own formulas. It is clear that Pennsylvania rejected the Medicare formula because it would be too expensive. The defendants then worked out a formula which would have produced add-ons in the range of 4% to 5%. This was never implemented, however, because of budgetary considerations. In the final analysis, the defendants simply allocated to disproportionate-share hospitals the funds available; this

turned out to produce the maximum reimbursement of 2.5%.

The statute does not mandate any particular level of payments for disproportionate-share hospitals. It does, however, require payments which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws"; and it requires that such rates are to be determined in accordance with standards which "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs".

Whether the Pennsylvania plan can properly be said to have taken the situation of disproportionate-share hospitals into account when it falls so

far short of meeting the medical assistance costs associated with disporportionate-share activities is a close question. By specifying either the Medicare system or an alternative system devised by the States, Congress seems to have contemplated that the State's plan would produce comparable results. The 2.5% override provided by the Pennsylvania Plan is only about 1/10 of the amount which would be payable under the Medicare analysis (2.5% versus 20.93%).

Recognizing that States are given a considerable amount of flexibility in this area, and that reimbursement rates are to be fixed by the State, not by this court, I am nevertheless constrained to hold that Pennsylvania's adjustment for plaintiff's disproportionate-share status misses the mark by so wide a margin as to

be inconsistent with the intent of Congress.

IV. PROCEDURAL ISSUES

[3] Finally, it seems clear that Pennsylvania's Medical Assistance Plan was adopted without compliance with the procedural requirements of Title XIX and the applicable regulations. Section 447.253(b) of the applicable regulations provides:

> "(b) Findings--Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:
>
> "(1) Payment Rates--
>
> "(i) the Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate

to meet the cost that must be incurred by efficiently and economically operative providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

"(ii) With respect to in-patient hospital services--

"(A) the methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs ..."

42 C.F.R. § 4471253(b) (1988).

So far as the record discloses, Pennsylvania did not make findings based upon empirical studies--on such matters, for example, as the characteristics of an

efficient and economical hospital operation, the impact of the proposed reimbursement rates upon hospitals' ability to survive, etc.--but merely certified that its plan complied with the statutory requirements. But, as stated by the Tenth Circuit Court of Appeals,

> "Mere recitation of the wording of the federal statute is not sufficient for procedural compliance. There is a presumption that the State will engage in a bona fide finding process before it makes assurances to HCFA that the required findings have been made. To rule otherwise would completely eviscerate the federal requirements so long as the magic words are submitted to HCFA. Amisub, supra, 879 F.2d at 797.

Indeed, our own Court of Appeals has expressly held that Pennsylvania's plan is procedurally defective, at least with respect to out-of-state hospitals. The court pointed out:

> "In structuring its out-of-state reimbursement program, Pennsylvania admits to gathering no information with respect to these hospitals' actual costs. No empirical analysis was conducted to measure the effects of the reimbursement program on out-of-state hospitals.... Federal law is not satisfied if a State merely makes conceptual policy decisions. A policy predicated upon provincialism and self-interest, not upon findings of reasonableness and adequacy, is unacceptable. We hold that the federal regulations unambiguously require the State to

make findings In failing to make these requisite findings, Pennsylvania violated federal law." West Virginia Hospitals, supra at 30.

I therefore conclude that the Pennsylvania plan was adopted without adequate compliance with the procedural requirements of the statute.

V.SUMMARY OF LEGAL CONCLUSIONS

For the reasons set forth above, I have concluded that the Pennsylvania Medical Assistance Plan was adopted without compliance with the procedural requirements of Title XIX and the implementing regulations because of the absence of meaningful findings based upon reasonable investigation. I have further concluded that, as applied to the plaintiff, the Pennsylvania Medical Assistance plan violates the statute, 42 U.S.C.A. § 1396a (a) (13) (A) (West

Supp.1989) both because it fails to provide payments at rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" and because the rates do not adequately "take into account the situation of hospitals [including plaintiff] which serve a disproportionate number of low-income patients with special needs;" the rates are properly characterized as arbitrary.

I accept defendants' argument that plaintiff has made no showing, on this record, that Medicaid patients are being denied reasonable access to in-patient hospital care. But the fact that such denial of access has not yet occurred provides no assurance of reasonable access in the foreseeable future. Indeed, the evidence presented justifies

the conclusion that, absent prompt corrective measures, denial of reasonable access to inpatient hospital care for Medicaid patients is almost inevitable.

VI. REMEDY

It is clear that the plaintiff is entitled to a declaratory judgment, and to an injunction requiring the defendants to bring the Pennsylvania Medical Assistance Plan into conformity with federal requirements. That much relief will therefore be ordered at this time. What is less clear, however, is the extent to which retroactive relief can be ordered, given the limitations of the Eleventh Amendment and Edelman v. Jordan, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974).

As explained in Bennett v. White, 865 F.2d 1395, 1408 (3d Cir. 1989),

> "It is one thing for a state to insist that the Eleventh Amendment prevents retroactive relief which affects its fisc. It is quite another to insist that the State can confer an unwanted bonanza upon the United States by refusing to make an accounting and recover available funds from the federal treasury."

The Eleventh Amendment does not, presumably, preclude prospective relief which directly affects the state treasury-- e.g., an injunction requiring that, pending modification of the Medical Assistance Plan, the defendants make payments to plaintiff at a higher level, so as to preclude further damage from the statutory violations. It would also be appropriate, under Bennett v. White, supra, to require the defendants to take appropriate actions to recapture, so far

as possible, additional sums from the federal treasury retroactively. But I believe it preferable to obtain additional clarification on these points before framing a final order addressing those issues.

ORDER

AND NOW, this 24th day of January, 1990, upon consideration of the arguments and evidence presented, it is hereby ADJUDGED that the Pennsylvania Medical Assistance Plan:

1. was adopted without compliance with the procedural requirements of the applicable federal laws and regulations;

2. applies payment rates which are arbitrary, and inadequate to meet the costs which must be incurred by efficiently and economically operated hospitals; and

3. applies rates which fail to adequately take into account the circumstances of hospitals which serve a disproportionate number of low-income patients with special needs.

IT IS THEREFORE ORDERED that the defendants shall promptly take all necessary steps to bring the Pennsylvania Medical Assistance Plan into compliance with federal requirements consistent with the accompanying Memorandum.

FINALLY, the parties are directed to clarify within ten (10) days their respective positions concerning the appropriate level of intermim payments pending modification of the Plan, and possible retroactive recovery of additional federal or other funds, consistent with Eleventh Amendment restrictions.

TEMPLE UNIVERSITY OF THE
COMMONWEALTH SYSTEM OF
HIGHER EDUCATION

v.

JOHN F. WHITE, JR., et al.,
Civ. A. No. 88-6646

United States District Court
E.D. Pennsylvania

Feb. 21, 1990.

Matthew M. Strickler of Ballard, Spahr, Andrews & Ingersoll, Philadelphia, Pa., for plaintiff.

Kate L. Mershimer, Deputy Atty. Gen., Harrisburg, Pa., for defendants.

MEMORANDUM AND ORDER

FULLAM, Chief Judge

By Memorandum and Order dated January 24, 1990, 729 F.Supp. 1093, I ruled that Pennsylvania's plan for funding Medicaid costs did not comply with the requirements of the federal statute, and would have to be revised. I left open for further proceedings the question of what, if any, interim relief

should be provided plaintiff Temple University, pending final adoption of a satisfactory plan by the defendants. These questions have now been addressed in further briefing, and at a hearing held February 20, 1990.

[1] I have concluded that Eleventh Amendment considerations preclude mandating additional payments on a retroactive basis-i.e., recalculating payments made to plaintiff before January 24, 1990. The Federal Government is responsible for 56% of these costs, but the Commonwealth treasury is the source of payment of 44% of these costs. Thus, unlike the situation in Bennett v. White, 865 F.2d 1395 (3d Cir.), cert. denied, ___ U.S. ____, 109 S.Ct. 3247, 106 L.Ed.2d 593 (1989), upon which plaintiff relies, to require the defendants to seek

increased retroactive allocations of federal funds (which should and would have been provided if Pennsylvania's plan fully complied with the federal statute) would inevitably require direct payments (to the extent of 44%) from the state treasury-a result precluded by Eleventh Amendment jurisprudence.

[2] This should not mean, however, that the defendants can await the eventual adoption of a revised plan without taking any steps to avoid further unnecessary damage to plaintiff from continued implementation of the defective plan at the funding levels which have been determined not to satisfy federal requirements. Although the task of framing an acceptable Medicaid plan must be left to the defendants, once this court's jurisdiction has been invoked, it

is appropriate to grant interim relief to mitigate irreparable loss which the plaintiff would otherwise suffer, pending final action on a revised plan.

Under the present plan, plaintiff's current payment rate is $2695.51. Plaintiff earnestly contends that full compliance with the requirements of the federal statute (i.e. full payment of costs experienced by efficient hospitals), would require that the rate be increased to $4380.32. The defendants suggest that, at most, the $2695.51 figure should be increased by 11.6% (by eliminating part of the "budget neutrality" reduction which produced the current rate); this would produce a payment rate of $3,008.19.

While it is entirely possible that, when the Pennsylvania plan has been

revised in order to bring it into full compliance with the federal statute, Temple's calculations may prove to be substantially correct, I am not prepared to make any such assumptions at this early stage. It is preferable, I believe, to establish an interim payment level based upon eliminating only the most obvious and clearcut inadequacies of the present plan.

One of the principal defects in the present plan is the lack of homogeneity among hospitals assigned to Class 1. If the lowest-cost, most dissimilar, institutions are eliminated from that group for purposes of calculating the rate, the remaining seven hospitals seem reasonabiy homogeneous in all significant respects. If only those seven hospitals are included, the basic rate would be

$3,084.23 (rather than the $2,805.85 figure which serves as the starting point under the present plan). Adjusted for inflation since 1987, using only the defendants' adjustments, the base rate becomes $3,265.66. I recognize that Temple makes a persuasive argument that the defendants' inflationary adjustments are incorrect; but I believe such refinements are best left to the final revisions the plan, and that some allowance should be made for the (faint, in my view) possibility that the new grouping unduly favors plaintiff.

A second major problem with the existing plan is its use of the arbitrary budget neutrality reduction of 14%. While it is probable that this factor should be eliminated altogether, it is conceivable that as much as 2.4% could be justified (based upon assumed differences between projections and actual costs).

Applying a 2.4% budget neutrality factor, the base rate becomes $3,187.28. With the agreed "capital add-on", the figure becomes $3,311.90.

The final question is what adjustment should be made for the fact that plaintiff serves a disproportionate share of indigent patients. The statute permits the defendants either to adopt the Medicare formula for that adjustment, or to devise their own appropriate adjustment. If the Medicare formula were applied, the disproportionate share add-on would be 21.37%. The existing plan uses, instead, a 2.5% figure. I remain convinced, as set forth in my earlier Memorandum, that Congress intended disproportionate share institutions to receive an adjustment in the same ball park as the Medicare calculation would produce, but without

limiting the states to that precise formula. Regardless of the correctness of that view, when the state, without explanation or justification, provides a disproportionate share add-on of only 2.5%, it cannot be said to have made due allowance for the situation of a disproportionate share institution.

The plaintiff argues that, since the State has not provided an acceptable alternative calculation of the disproportionate share add-on, the court should enforce the other alternative sanctioned by Congress, namely, the disproportionate share add-on which the Medicare formula would produce. I do not believe, however, that this would represent the best interim solution; the defendants, too, must deal with budgetary shortfalls.

Although the 21.37% suggested by Medicare will not be mandated, it does

seem to me that, even on an interim basis, the disproportionate share add-on should be not less than 10%. Stated otherwise, it is utterly unrealistic to suppose that the actual incremental costs associated with Temple's disproportionate share status are much less than one-half of what Medicare would estimate them to be.

Applying the 10% disproportionate share add-on produces a final payment rate of $3,643.09. The defendants will be ordered to apply that rate with respect to all bills paid or to be paid on or after January 25, 1990, pending defendants' submission of their revised plan.

[3] The defendants have requested that, in the event interim relief is ordered, plaintiff be required to post

security, guaranteeing repayment in the event the interim payments ordered by this court exceeds the amounts ultimately determined to be appropriate. Given the ongoing relationship between plaintiff and the defendants, however, it is reasonable to suppose that the defendants would be able to recapture any such excessive payments, by additional reductions in future payments, in the unlikely event that becomes necessary. I believe it is inappropriate to make a bad situation worse for both sides by imposing upon plaintiff the additional expense associated with obtaining a surety bond which, as a practical matter, would be of little real benefit to the defendants.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

TEMPLE UNIVERSITY-OF COMMONWEALTH SYSTEM OF HIGHER EDUCATION.....	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., et al.,	:	NO. 88-9848

ORDER

AND NOW, this 21st day of February, 1990, it is ORDERED:

That, pending final revision of its Medicaid plan in conformity with this court's Memorandum and Order of January 24, 1990, the defendants shall, with respect to all of plaintiff's bills paid on or after January 25, 1990, utilize a payment rate of $3,643.09.

IT IS FURTHER ORDERED that if it is later finally determined, either in this litigation or in the implementation of an acceptable revised medical assistance

plan, that the amounts received by plaintiff pursuant to this Order are excessive, plaintiff shall promptly refund the excess, either by payment or by credit against future entitlement.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

HOSPITAL ASSOCIATION OF PENNSYLVANIA, et al.	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., Secretary of Public Welfare,	:	NO. 88-9848

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

ALBERT EINSTEIN MEDICAL CENTER, et al.,	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., Secretary of Public Welfare,	:	NO. 88-8831

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES D!STRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

HAHNEMANN UNIVERSITY HOSPITAL, et al.,	:	CIVIL ACTION
v.	:	
JOHN F. WHITE, JR., Secretary of Public Welfare, et al.,	:	NO. 88-9132

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

FRANKFORD HOSPITAL	:CIVIL ACTION
v.	:
JOHN F. WHITE, JR., Secretary of Public Welfare, et al.,	:NO. 88-8927

ORDER

AND NOW, this 1st day of March, 1990, upon consideration of the various pending applications for interim relief, and for the reasons stated in this court's rulings on interim relief in the case of Temple University v. John F. White, Jr., C.A. 88-6646 (to the extent those reasons apply to all hospitals, without regard to their classification or other individual distinguishing features), it is ORDERED:

1. That, with respect to all plaintiffs, and with respect to all bills paid or to be paid on or after the date of this Order, the defendants shall apply

a rate calculation which does not include any "budget neutrality" adjustment in excess of 2.4%.

2. This Order is without prejudice to other aspects of the pending applications for additional interim relief, or to further such applications.

(s/John P. Fullam)
Ch.J.